SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS : CIVIL TERM : PART 13

----------X

CLYDE ANDERSON and MAXINE ANDERSON,

Plaintiffs,

- against -

THE AMERICAN TOBACCO COMPANY, LORILLARD TOBACCO COMPANY, PHILIP MORRIS INCORPORATED, R.J. REYNOLDS TOBACCO COMPANY, LIGGETT & MYERS TOBACCO COMPANY, BROWN & WILLIAMSON TOBACCO CORPORATION, TOBACCO INSTITUTE, INC. and THE COUNCIL FOR TOBACCO RESEARCH-U.S.A, INC.,

Defendants

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Index No. 42821/97

360 Adams Street
Brooklyn, New York
June 5, 2000

B E F O R E :

HONORABLE HERBERT KRAMER,
Justice, and a jury

(Appearances same as previously noted*)

(Joseph Hubicki, Esq. is not present this day.)

MARK L. BOWIN
DIANE DORSEY
ESTHER SPIELMAN
Official Court Reporters

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(The following takes place outside the presence of the jury.)

THE COURT: On the record.

MR. KACZYNSKI: I'm handing to plaintiff's the exhibit designations for Dr. Debethizy, who will be our witness tomorrow.

And if I understand correctly, that Mr. Anderson is going to testify this morning to answer those two or however many questions that your Honor permitted, the proximate cause questions. If that's the case, I've got some evidentiary issues we should handle first.

THE COURT: Okay. We're ready.

MR. KACZYNSKI: I have about a dozen or so articles or advertisements about smoking cessation issues. The earliest is 1955; the latest is 1968. These are from the Daily News, the New Amsterdam News, which would be New York media markets reasonably calculated to reach Mr. Anderson, self-authenticating --

THE COURT: I see you quote me well.

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MR. KACZYNSKI: Yes, sir. And none of these have previously been objected to and none --

THE COURT: Why don't you show it to him.

MR. KACZYNSKI: I have.

THE COURT: Give me the era.

MR. KACZYNSKI: '55 through '68. Not

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one every year, but that's the range.
THE COURT: By the way, I thought we did well on Friday for the amount of time we had on that.
MR. GORDON: I know we need to continue that, but we did make some progress.
THE COURT: Off the record.
(Discussion off the record.)
MR. KACZYNSKI: Shall I read into the record the exhibit numbers?
THE COURT: Okay.
MR. KACZYNSKI: A3483; A3513; A3547; A3627; A3678; A4069; A4070; A4086; A4087; A4097; A4109; A4112; A4134; A4138 and A4296.

THE CLERK: These are all going in as evidence, right, with no objection?
MR. KACZYNSKI: There's no objection.
THE COURT: Did you have something?
MR. FINZ: Yes, your Honor.
There are a series of questions that we would be asking Mr. Anderson this morning, and rather than ask them in the presence of the jury, with the possible objections that may erupt and the introduction, perhaps we can discuss them in advance.
THE COURT: Why don't you do it right now?
MR. FINZ: That will be fine.

C L Y D E A N D E R S O N,

Having been previously duly sworn, resumed the stand and testified as follows outside the presence of the jury:

THE COURT: You remain under oath, sir.
MR. FINZ: May I proceed, your Honor?

FURTHER REDIRECT EXAMINATION

BY MR. FINZ:

Q Mr. Anderson, if you had been warned by Philip Morris in 1960 or 1961 that the cigarette smoke of Parliament cigarettes contained chemicals --
THE COURT: Counsel, sustained as leading.
"What would you have done, if anything" -- Go ahead.
Q What, if anything, would you have done if you had been warned by Philip Morris in 1960 or '61 that the cigarette smoke of Parliament cigarettes contained chemicals that caused lung cancer?
MR. QUIGLEY: Objection.
Calls for speculation.
THE COURT: I will allow it.
A I would have never started smoking.
Q What, if anything, would you have done if you had been warned by Lorillard that the cigarette smoke of Kent cigarettes contained chemicals that

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caused lung cancer?
MR. RANDLES: Object to form. Object on the basis of speculation.
THE COURT: Same ruling.
A I would never have started smoking.

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C. Anderson-Redirect/Finz

Q What, if anything, would you have done if you had been warned by R.J. Reynolds that the cigarette smoke of Salem cigarettes contained chemicals that caused lung cancer?
MR. KACZYNSKI: Object to form. Object to speculation.
THE COURT: Same ruling.
A I would have never started smoking.
THE COURT: Off the record.
(Discussion off the record.)
THE COURT: Go ahead.
Q What, if anything, would you have done had you been warned by Philip Morris in 1960 or 1961 that Parliament cigarettes contained a drug that would addict you to cigarette smoking?
MR. QUIGLEY: Objection. Speculation.
THE COURT: Overruled.
MR. QUIGLEY: Also object to the form, especially the use of the word "drug."
THE COURT: "Drug." Sustained. You're right. How about "compound"?
MR. FINZ: Compound. Thank you.

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C. Anderson-Redirect/Finz

Q What, if anything, would you have done had you been warned by Philip Morris in 1960 or 1961 that part cigarettes contained a compound that would addict you?
MR. QUIGLEY: Same objection. Speculation.
THE COURT: Overruled.
A I would have never started smoking.
Q What, if anything, would you have done had you been warned by Lorillard that Kent cigarettes contained a compound that would addict you?
MR. RANDLES: Object to the form and on the basis of speculation.
THE COURT: Overruled. You're still objecting as to form?
MR. RANDLES: You bet.
A I would never have started smoking.
Q What, if anything, would you have done had you been warned by R.J. Reynolds that Salem cigarettes contained a compound that would addict you --
MR. KACZYNSKI: Objection, your Honor. Speculation.

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THE COURT: That would be an addictive.
Q (Cont'g) -- that would be addictive?
A I'd have never started smoking.

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THE COURT: Then that objection is overruled, for the record.
MR. FINZ: May we go off for a moment? This is the one question that remember you said I could ask.
THE COURT: Go ahead.
MR. FINZ: Fine. Thank you.
Q If you knew that the tobacco defendants concealed and suppressed the fact that they knew since the early 1950's that cigarette smoke contained cancer-causing chemicals, would you have started to smoke?
MR. KACZYNSKI: Objection, your Honor. Form and speculation.
THE COURT: Sustained as to form.
MR. SHEFFLER: I object, your Honor. There's no claim against my client so I object to the use of the word "tobacco defendants."
MS. STRAUB: I join that objection.

MR. MERRITT: I join.
MR. QUIGLEY: I object to the assumption of facts not in evidence.
THE COURT: I sustained it.
Why do you keep objecting? You want me to change my mind? I don't understand.
MR. SHEFFLER: Did you sustain it? Oh, sorry.
THE COURT: Join us, Counselors.
Q What, if anything, would you have done if you knew --
THE COURT: Sustained.
MR. FINZ: May we approach on that one, Judge?
THE COURT: Yes.
(Discussion at the bench off the record.)
Q If you had all --
THE COURT: No, I think you have to deal with that in a specific fashion by documents.
We're going to read back the record on these questions. I'm going to bring

the jury in. Don't read the objections. I've ruled on it, but they are part of the record. I will reserve that question.
Where are those other documents?
MR. KACZYNSKI: The ones we just admitted this morning?
THE COURT: No. He had some other documents, I thought.
MR. LONDON: Right. Your Honor --
THE COURT: I want that either read in or put it into evidence when the jury comes in, and let's move this process along.
Ma'am?

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MR. LONDON: Your Honor, I just received --
MS. STEVENS: We received a fax last night of additional documents from Mr. London and we were just kind of talking about them. We have several that we maintain objections to.
THE COURT: Let's deal with it now. Meaning that were not ruled on by me?

MS. STEVENS: Your Honor, I don't think all of them had been. Several were -- two were subject to a privilege claim; is that correct?
MR. SHEFFLER: At least two.
MR. LONDON: They're claiming privilege now, but they were released in Minnesota.
THE COURT: But I already made a ruling on that. So follow my ruling.
MR. LONDON: You made a ruling saying they're not privileged, but then you issued a new ruling: We'll look at it document by document. We need to look at this, too.
THE WITNESS: Can I step down?
THE COURT: You can step down.
(Witness leaves the stand.)
MR. LONDON: First one we have is plaintiff's 268. I received no word that it's being objected to.
MR. QUIGLEY: Your Honor, we haven't seen his list. It came in Sunday night at six o'clock --

MR. LONDON: It did not come in at six o'clock.
MR. QUIGLEY: I just found out from Ms. Stevens what --
MR. LONDON: You weren't in your office on Sunday night?
MR. QUIGLEY: No, I took the night off.
THE COURT: Let's do something --
MR. LONDON: Plaintiff's 268.
MR. SHEFFLER: I did get notice of this one before because this was one of the ones that Mr. London had said he was going to introduce before, and there are objections to it.
This was one of the documents that I think was misidentified by Miss Stevens because we had never received it at the time we went through the documents of Brown & Williamson --
THE COURT: What is the document?
MR. SHEFFLER: It is a memorandum, from a JVR.
THE COURT: Who is?

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MR. SHEFFLER: I do not know. "John." It's a memo to a Mr. Finch.
THE COURT: Who is?
MR. SHEFFLER: I don't know, but he's probably with Brown & Williamson.
MR. LONDON: It's on Brown & Williamson letterhead.
THE COURT: What's the objection?
MR. KACZYNSKI: The objection is as follows.
First of all, it's hearsay within hearsay. He's reporting on a meeting who said what. They're not admissions.
THE COURT: Was it a meeting -- who was in attendance?
MR. SHEFFLER: Bert Goss, G-o-s-s.
THE COURT: From Hill & Knowlton.
MR. SHEFFLER: Yes. Ed Hart, who was from Hill & Knowlton. W. T. Hoyt, H-o-y-t, from Hill & Knowlton. C. C. Little from TIRC, and R.C. Hockett (phonetic) --
THE COURT: Can I see the document? I'm not being helped here.

MR. LONDON: Here you go. Judge, it's a business record.
THE COURT: That doesn't eliminate the other exceptions.
I overruled the objection to this. Why are we visiting this one?
MR. SHEFFLER: No, this was one of the ones that was missing.
THE COURT: No, it wasn't. Not 268.
MS. STEVENS: Your Honor, he's telling me I made a mistake on my chart with this one, which is entirely possible.
MR. SHEFFLER: We never got this one during the course of the plaintiff's -- we have it listed as missing. I got it for the first time last week, so that's the reason why the objection is raised now. We never addressed --
THE COURT: Mr. Hart is a member of the Tobacco Institute.
MR. SHEFFLER: It says "Hill & Knowlton" in parenthesis.
That very well may be; I don't know.

THE COURT: He also may be --
MR. SHEFFLER: Could be.
THE COURT: Maybe he's then one of your people.
MR. SHEFFLER: Who? There's nobody from my people on here.
THE COURT: Wait a minute, no. Mr. Merritt's people. This came from your web site.
MR. SHEFFLER: Yes, I believe so. I'll take the representation of

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Mr. London that it did.
Did it? I don't know if it did or not.
MR. LONDON: The document is there. It speaks for itself.
THE COURT: Well, I don't know why this is against you. You weren't there.
MR. SHEFFLER: I don't know, your Honor.
THE COURT: Who said it is?
MR. SHEFFLER: Maybe an objection would be, what is the plaintiff using this document for?

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THE COURT: It's against the parties who were there. Why is that a problem?
MR. SHEFFLER: I thought he was offering it against -- he said -- when he gave the document over, he said, "Here's a document for you."
MR. LONDON: I believe CTR is there.
THE COURT: The parties who were there.
MR. LONDON: I identified it to you Mr. Sheffler because it's your letterhead. That's the only reason, I said, "Here, Bruce."
MR. SHEFFLER: If it's not against me, Judge, I'll shut up. I'll sit down.
MR. MERRITT: Judge, I'm somewhat at a disadvantage. I don't believe this is our document. I don't believe somebody else who writes about us, makes a hearsay statement about us, that shouldn't be admissible against us. I can't even tell from this copy whose document this is. But I don't believe it's TIRC's. I could have checked it out if I had an advance

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warning on this. I don't recognize J.V.B. and I don't recognize --
MR. LONDON: I think he's from Brown & Williamson. It's on Brown & Williamson's letterhead.
MR. MERRITT: Then I would object to a hearsay statement by Brown & Williamson about my client which was not made by my client.
As far as I can tell, this was not even contemporaneously given to my client.
THE COURT: Oh, no, this is admitted as to Brown & Williamson.
MR. SHEFFLER: It is? Okay. Then my objection, your Honor, is as follows:
There's a motion in limine on point dealing with lobbying efforts, referring to the motion in limine --
THE COURT: I'm going to give you a ruling as to this, and I will so instruct the jury upon request.

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This is admitted against Brown & Williamson. It is admitted

against any other defendant wherein there is a reported admission of some kind. I read it, and I haven't parsed that out, but right now it's Brown & Williamson and it is admitted.

MR. SHEFFLER: For what purpose, your Honor? Conspiracy?

Is this notice?

THE COURT: It doesn't have tobacco limited in that fashion. It's a business record which talks about the issues in this case.

MR. SHEFFLER: Your Honor --

THE COURT: What's the next one?

MR. LONDON: Plaintiff's 385.

MR. SHEFFLER: Your Honor, may I make one point on this?

THE COURT: Yes. Give me 385.

Who are you putting it in against --

MR. SHEFFLER: Can we limit the document to exclude the portions dealing with lobbying and litigation?

THE COURT: Lobbying and litigation, yes.

MR. SHEFFLER: Those will be redacted.

MR. LONDON: Next is plaintiff's 385.

Is there an objection? This was actually an open document.

THE COURT: Open document? Let me see it. Where did it come from?

Can you tell me who this is being offered against.

MS. STEVENS: Your Honor, that document is full of hearsay throughout.

MR. SHEFFLER: Who is it being offered against?

THE COURT: Well, it would be helpful if somebody told me.

MR. LONDON: All defendants, your Honor.

THE COURT: What is it?

MR. LONDON: It's a report that defendants attended a conference or meeting concerning the policy that the defendants would be implementing --

MS. STEVENS: Your Honor --

MR. KACZYNSKI: That's not even close.

MR. SHEFFLER: Absolutely not. I know this document, your Honor, and that's absolutely not the case.

THE COURT: I'm sorry. Where did it come from?

MR. SHEFFLER: It came from the files

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of TRC, Tobacco Research Counsel, which is United Kingdom Tobacco Manufacturing Association; has nothing to do with any of the defendants in this case.

THE COURT: What?

MR. SHEFFLER: It's a United Kingdom Association of Tobacco Council in England. Jeffrey Todd is the "G.E.T." referred to there.

But it's not a document from any defendant in this case. It's not a document that has anything to do with the defendants in this case directly.

MS. STEVENS: And it never went to any defendant in this case, either.

MR. KACZYNSKI: And your Honor has it down as open, which means they would have

to lay a foundation, which they cannot do and through five weeks into the trial have not done.

THE COURT: You don't know where this came from?

MR. LONDON: It came from one of the defendant's internet web sites. I don't have the document in front of me right now.

MR. RANDLES: Your Honor, I can tell you how it got on the web site.

It was produced in Minnesota pursuant to discovery requested to English companies. And they put it in the Minnesota repository. Our clients got it in the Minnesota litigation.

THE COURT: That doesn't have to do with admission.

MR. LONDON: Your Honor, if that's Mr. Randles' representation to the Court on the record, that they have never had this document, we'll withdraw it pending investigation of that comment.

MR. RANDLES: I can remember when we

first saw it.

MR. LONDON: That's a bold statement to make.

MR. RANDLES: It's a true statement.

MR. LONDON: 402, which has already been admitted. 402 is a, quote, privileged document.

THE COURT: Let me see it. I have to go through it.

MR. LONDON: It was de-privileged in Minnesota.

THE COURT: But I've already ruled --

MR. LONDON: I understand, your Honor, going back to that original ruling and looking at this document --

THE COURT: Who are these people? Where did this come from?

MS. STEVENS: Can we see 402?

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THE COURT: General counsel of five companies were there.
MR. SHEFFLER: And outside counsel as well.
THE COURT: And a Senator. So how is it this privileged?

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MR. MERRITT: Because the Senator was working for the Tobacco Institute at the time, former Senator. Senator Clements was a former Senator.
MR. KACZYNSKI: Employee of the Tobacco Institute.
THE COURT: Whose Alan Topal?
MR. SHEFFLER: National counsel for Tobacco Institute.
MR. SHEFFLER: Dave Heard (phonetic) was outside counsel at the time; Janet Brown was outside counsel at the time.
THE COURT: Wait a minute. It deals here with the preparation of a white paper. Does anybody --
MR. LONDON: The white paper's in evidence, your Honor.
MR. SHEFFLER: It's not.
MR. MERRITT: The white paper that's in evidence is from 1954. This is a completely different -- a white paper is a common term used, as your Honor knows.
THE COURT: No, I don't. I know what it means in England. I don't know what

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it means here.
What does it mean here?
MR. MERRITT: It just means a position paper, essentially. The white paper that's in evidence was a position paper on some scientific issues --
THE COURT: So where is this scientific --
MR. SHEFFLER: It may have been used in litigation. We don't know what it was. A white paper on issues raised in the litigation -- which outside litigation counsel --
THE COURT: Well, that's what I would like to find out. This does not look like privileged information to me. It's being transmitted to Congress. This is not lawyers acting as lawyers. This is lawyers acting as counselors.
MR. SHEFFLER: Lawyers engaged in lobbying efforts on behalf of their clients is privileged.
THE COURT: No, this is not lawyers engaging in lobbying efforts.

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MR. SHEFFLER: Your Honor, if the lawyers were giving advice to the Tobacco Institute as to how it should lobby or

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how it should proceed -- and I haven't had a chance to read the document.

THE COURT: Wait a minute. Here.

"The general counsel said they could not approve a serious approach to Vorwald at this time."

That ain't law.

MR. SHEFFLER: I don't know who Vorwald is.

THE COURT: It's a man's name.

MR. SHEFFLER: I don't know who he is. Was he a witness who was going to be testifying in litigation?

THE COURT: No, it was somebody doing research.

MR. SHEFFLER: Judge, for what purpose? They were funding research --

THE COURT: Counsel, I would like to know what is relevant in this document?

MR. LONDON: Your Honor, it's a report of a meeting setting forth a

conspiracy --

THE COURT: What is the conspiracy? What does it say here? "We need to act."

MR. SHEFFLER: We need to lobby; we need to engage in lobbying efforts, which I believe was protected.

MR. LONDON: And do research; which wasn't done.

MR. FINZ: The point is, at this meeting, the representatives were there. This is, in essence, a report of that meeting. Now, whether or not whatever's contained in here goes to some issue in the case.

THE COURT: It has to go to some issue in the case. What is the issue?

MR. FINZ: The issue in the case, your Honor -- first of all --

THE COURT: You tell me what purpose this can come in for?

MR. FINZ: First of all, we have been setting forth that since the "Frank Statement," there has been a concerted effort to proceed with a public relations

program. This is but an extension of that effort, and this goes to that link.

THE COURT: See, I don't know what's in this document that one should ignite an objection.

MR. SHEFFLER: Your Honor, I do want to protect the privilege because I think there is a privilege --

THE COURT: I want to tell you something. I don't see any privilege here. That's not the issue.

If there were a privilege dealing with litigation and it was apparent, I've already ruled I would be the first one to

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precinct the privilege.
MR. SHEFFLER: Your Honor, just respectfully, for the record, there is a privilege recognized in New York for efforts engaged in lobbying. There is a privilege. There is a privilege for counsel engaged in lobbying efforts. There is a privilege.
THE COURT: And I would have no problem excluding that because of other

reasons. It's got to do with the comments about research. And the mere fact that they got together. That's all. I don't see anything else in there.
MR. FINZ: It's merely an extension -- this, coupled with a lot of other things, your Honor, is just one little piece of that puzzle. Something for the jury to assess; accept or reject.
THE COURT: You know what, I'm going to allow only the representation at that meeting and nothing in the document.
MR. SHEFFLER: The representation of the general counsel of the companies?
THE COURT: Yes. That's all I'm going to allow.
Next.
MR. LONDON: Next one is 411, Judge, Plaintiff's 411, which is a similar document.
The following were individuals who all met at Hilton Head, South Carolina. The purpose was to discuss the scientific aspects of problems facing the tobacco

industry (handing.)
It's the exact same document.
MR. SHEFFLER: Judge, since we don't have it, can you tell us who it's being offered against?
THE COURT: Meeting of the scientific directors.
MR. SHEFFLER: It's being offered against?
MS. STEVENS: Your Honor, there's no base numbers on this document. I don't know whose files it came from.
MR. LONDON: My goodness. It came over the internet.
MS. STEVENS: It didn't come off the internet without the base numbers.
MR. LONDON: This is from the internet.
MS. STEVENS: Every single document on the internet has base numbers --
MR. LONDON: These are their agents, officers, who's Harrington Heard? Someone denied they didn't know who Topal was.

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MR. SHEFFLER: I said I knew he was a lawyer for T.I.

MS. STEVENS: Your Honor, every document that comes from a web site has base number on it. This does not. It doesn't tell us whose file it came from.

MR. LONDON: I'll make a discovery request for plaintiffs to produce plaintiff's 411, a letter dated --

MS. STEVENS: February 19, 1968.

MR. MOLLON: Judge, we're past making requests for discovery. They've gotten months and months of --

THE COURT: Wait a minute. Are you telling me this does not have a base number?

MR. LONDON: Your Honor, that's the copy.

THE COURT: This was marked "open" on the report I'm reading from. So you have to establish a basis for it. I don't care how you do it. Be my guest.

Now, let me see what's in here. This looks like it should be allowed, even

though Covington & Burley is a law firm. He's meeting with scientific directors here.

MR. FINZ: Your Honor, any time we're dealing with documents that are old documents where there is no specific identification of a number, now, obviously, we're going to run into that problem. But here there can be no dispute whatsoever that this is a document that came from the tobacco industry.

THE COURT: There is, obviously, a dispute.

MR. FINZ: Then it's not a bona fide dispute.

THE COURT: It was marked "open" four months ago. Now, I don't know why I'm dealing with this. The document is otherwise admissible. Prove it. Next.

I mean, I don't have to waste all of this time on this. You know it's an open document. Why are you bothering? Let's go on.

MR. LONDON: Plaintiff's 490 --

THE COURT: I don't have to regurgitate all of this. Is that an open document, too?

MR. LONDON: 490 was the videos we showed.

MS. STEVENS: We have no objection to it.

MR. KACZYNSKI: We have no objection, other than I want to preserve the

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objection we have to Dr. Pollay's authentication.

MR. LONDON: Plaintiff's 704 was already ruled admitted.

THE COURT: So we don't have to talk about it.

MR. MOLLON: It wasn't ruled anything. This is the first time the document came up. And as far as I can tell, it's a P.M. document --

MR. LONDON: Philip Morris design document from 1962 trying to design their cigarette more like a Philip Morris cigarette.

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MR. MOLLON: It has nothing to do with this. The person who wrote this isn't a designer. He's an executive of the company.

THE COURT: I don't care. What's the difference? Whose objecting to this?

MR. MOLLON: Philip Morris.

MR. KACZYNSKI: Well, if it's discussing Reynolds, I'm objecting as to hearsay.

THE COURT: The objection was overruled. Why are we now redoing it? Why are we now going over objections that I've ruled on?

MR. MOLLON: Your Honor, as far as I know, this document -- the Philip Morris documents were not ruled on.

THE COURT: Why am I going over objections that I have ruled on?

MR. QUIGLEY: Your Honor never got to the Philip Morris documents in April. We never addressed them.

THE COURT: This is not a Philip Morris document.

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MR. MOLLON: Okay, then. It's a different Exhibit, then. The one I'm looking at, 704, is a Philip Morris document. It's on Philip Morris' letterhead.

THE COURT: I'm looking at 702. What did you say? 704?

MR. LONDON: 704.

THE COURT: What is this? Let me know what it is.

MR. LONDON: It's a design document from Philip Morris dated February 5, 1962.

THE COURT: What's the objection? That it's not a Philip Morris document? What's the objection?

MR. MOLLON: No, that's not the objection, your Honor.

THE COURT: What is the objection?

MR. MOLLON: The objection is it is a Philip Morris document that talks about

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nothing other than Reynolds' products for which they have no basis for knowing anything about it.

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THE COURT: It's a Philip Morris document asking a question of a scientist about a report -- that's admitted.

MR. MOLLON: Against?

THE COURT: Whoever the author is.

MR. LONDON: Plaintiff's 832.

THE COURT: What?

MR. LONDON: Plaintiff's 832. This is a document dated October 18, 1961. It's a report, Tobacco Industry Research Committee, attended by most of the tobacco defendants here.

THE COURT: All right. What's the problem?

MR. MERRITT: In light of your ruling --

THE COURT: It's open.

MR. MERRITT: From my point, we'll withdraw the document. It's one of our documents. It's a business record. There is included hearsay in it. I think that's the basis for the objection.

THE COURT: That objection is to any mention at that meeting, to anything in

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that document which refers to them or is an admission.

MR. MOLLON: Philip Morris' objects to any reference in the document to Philip Morris --

MR. LONDON: It was a report done at the time of this meeting --

THE COURT: That's right.

MR. LONDON: -- talking about who was there, what was discussed, what plan of action to take, what Dr. Little would be doing on behalf of the industry through his role at TIRC; what the industry suggested.

THE COURT: Is there any indication of who the copy was sent to?

MR. LONDON: There is. It just runs through attendance. The itinerary of the meeting.

THE COURT: Attendance will go into evidence. The balance of the document will go in against the author -- company.

Next.

MR. LONDON: Plaintiffs' 838, which I

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don't think there's an objection to.

MR. MOLLON: 838, I think you already put in last week.

MR. LONDON: Okay. Plaintiff's 1237 and 1238.

THE COURT: How many more of these do

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you have?
MR. LONDON: Four or five.
THE COURT: Why do we have to do this now?
MR. LONDON: We'll do it later --
THE COURT: Why do we have to do this when we had an opportunity to do this earlier? Why am I wasting trial time on this?
MR. LONDON: When would you like me to do it, your Honor?
THE COURT: Why didn't you have this done?
MR. LONDON: We were trying to work this out this morning.
THE COURT: Why didn't we do it Friday when we had time? Why are we doing this now?

MR. LONDON: Because we need rulings, on certain documents, Judge.
THE COURT: Give me all the documents you need rulings on; let me hear. Give them to me.
MR. FINZ: Do it later.
THE COURT: There is no "later." Give them to me.
MR. LONDON: 1237 --
THE COURT: Give them to me.
MR. LONDON: Oh, the documents.
THE COURT: There was adequate time to do this earlier, so I don't have to keep this jury waiting. I don't need to reinvent the wheel here. This is a massive waste of time.
Now, who is objecting to this number, 1237, and why?
MS. STEVENS: Based upon your Honor's ruling, we'll withdraw our objections to 1237.
THE COURT: Who else is objecting?
MR. SHEFFLER: Your Honor, we don't --

MR. QUIGLEY: Judge, apparently a fax came to our offices last night. We don't know what these documents are. We don't have them in front of us.
MR. LONDON: They knew this last week. I identified this document as one of the ones we wanted to offer.
MR. QUIGLEY: If we had the document in front of us, we could tell you whether we object.
MR. FINZ: Tom, you knew last week --
MS. STEVENS: Your Honor, 1238 is Bowman Gray's Congressional statement. You ruled it's admitted. I ask any part that does not constitute an admission by Mr. Gray --
THE COURT: Cull this over between

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you and do it.
MS. STEVENS: The next two, 1261 and 1262 are ruled "open" by your Honor, about public statements from 1984 from Reynolds.
MR. KACZYNSKI: Pertaining to no cause of action remaining in this case.

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THE COURT: What year is that?
MS. STEVENS: 1984, your Honor.
THE COURT: Why are you reading a 1984 statement?
MR. LONDON: It's an admission, your Honor.
THE COURT: Of what?
MR. LONDON: Denying causation.
MS. STEVENS: Your Honor, I think we excluded 1262 with one witness.
MR. KACZYNSKI: They tried to use 1262 with Dr. Whelan. We had a bench conference. Your Honor said they couldn't use it. It's back.
MR. LONDON: I don't believe we used it with Dr. Whelan we --
THE COURT: Why you are you using '84 statements?
MR. LONDON: It's an admission.
THE COURT: What cause of action?
MR. LONDON: It goes to causation, your Honor. They're denying causation.
THE COURT: I don't care if they deny it; you have to prove it.

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Post-'69, it has nothing to do with fraudulent suppression.
Here. What else. All I'm left with is 1237.
MR. LONDON: Actually, your Honor, there are two documents that I don't have copies, of 1535 and 1538, which I was just told this morning defendants are objecting to.
THE COURT: This looks like it's admissible, 1237, against everyone. Hold it until they all agree.
Bring in the jury.
MR. LONDON: There were two others, Judge, that I don't have copies of because I thought they were in evidence, 1535 and 1538. If you have them in your chart.
THE COURT: They both seem to be admitted under the guideline I have.
What's the problem with them? Give it to them and let them look at it.
Bring me in the jury.
MR. MOLLON: Can we have a

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representation that that's it --
MS. STEVENS: Your Honor, your Honor,

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Mr. London sent a letter last evening reflecting these documents and listing the documents he thinks are in evidence. We have a few disputes over that; but at some point, I'd like to read in the record what is certainly in, just in numeric order.

THE COURT: I thought we have agreed as to what is in evidence.

MS. STEVENS: I think we pretty much have.

MR. LONDON: I think we're in agreement.

MS. STEVENS: We have seven documents that Mr. London listed in the beginning paragraph that we have as excluded. Two we just took care of as in.

The other five, Mike?

MR. LONDON: 1055 we withdrew because it was a draft of another document.

MS. STEVENS: 1262.

MR. LONDON: He just excluded --

MS. STEVENS: 1177.

MR. LONDON: 1262, he said he'd keep open.

MS. STEVENS: No, Mike. He just said, no, it's '84.

MR. LONDON: Okay. It's out.

MS. STEVENS: 1177.

MR. LONDON: That's in.

MS. STEVENS: 1177 is not in, Mike. If you can find me a transcript cite, it was excluded.

MR. MERRITT: It was excluded.

MR. LONDON: Okay.

THE CLERK: Okay, what?

MS. STEVENS: 1177 is out. 752 I think we just took care of.

MR. LONDON: 752 we didn't take care of. 752.

MR. MOLLON: It was not in. You tried offering it. You tried reading the paragraph you wanted to offer. The Judge excluded that.

MR. LONDON: I thought we just had to redact. That's that Jet document.

MR. MOLLON: That's exactly what the document is. You said "withdrawn" on the record and it's never come up again. That specific portion of the document was taken out.

MR. KACZYNSKI: Page 3173 of the transcript:

"MR. FINZ: Plaintiff's Exhibit 752, please.

"THE COURT: I appreciate you objecting before questions. That is very helpful.

"MR. FINZ: May we approach?

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"THE COURT: Yes. Somebody tell me what the number is? 752."

Bench conference, at which it was excluded. The next thing we have is it moves on to the next exhibit.

MR. LONDON: We'll withdraw 752. 514?

MS. STEVENS: I have it open, and I don't have you offering it again.

(Jury enters the courtroom.)

THE COURT: We've done something in your absence. The plaintiff was recalled to the stand. We're going to read those questions and answers.

MR. KACZYNSKI: Your Honor, thereafter, do I have an opportunity to cross-examine the plaintiff?

THE COURT: If that's what you wish.

MR. KACZYNSKI: Thank you, your Honor.

(Reporter reads as requested questions and answers of Mr. Clyde Anderson, as elicited above.)

THE COURT: Return to the stand, sir.

C L Y D E A N D E R S O N,

The plaintiff herein, having been Previously duly sworn, resumed the stand and testified as follows:

COURT OFFICER: Sir, be reminded, you're under oath.

MR. KACZYNSKI: Proceed, your Honor?

Good morning, ladies and gentlemen. Welcome back.

FURTHER RECROSS-EXAMINATION

BY MR. KACZYNSKI:

Q Good morning, Mr. Anderson.

Mr. Anderson, you had not yet started smoking in 1956, had you?

A That's correct.

Q Mr. Anderson, I want to show you -- Put the Elmo on, please.

This will be the New York Daily News April 15, 1956, Exhibit A3480. You see that title there, Mr. Anderson; "Isolate Small Cancer Factor in Cigarette Tar"?

A Yes.

Q All right.

"The active fraction is known to be soluble in carbon tetrachloride and contains a number of as yet unidentified polycyclic hydrocarbons. It also contains benzpyrene, a known cancer-causing agent, but, according to the investigators, in such small quantities that it cannot account for the cancer-producing activity."

See that Mr. Anderson?

A Yes.

Q This is a story about chemicals in

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C. Anderson-Recross/Kaczynski

cigarette smoke prior to your picking up your first cigarette, correct?

MR. FINZ: Your Honor, I'm going to object to that question.

You gave a curative charge as to how that could be used; not for the truth. For notice.

MR. KACZYNSKI: For notice. Correct. Absolutely.

Q This is an article in the New York Daily News about a chemical in cigarette smoke before you started smoking, isn't it?

A In the Daily News?

Q That's right.

A You said it was there. I didn't see it.

Q Mr. Anderson, you had not yet begun smoking Salem cigarettes in 1962; that's correct, isn't it?

A In '62?

Q Yes.

A 'Round about.

Q Let me show you an article New York Daily News September 20th, 1962. "Family Doctor" column entitled:

C. Anderson-Recross/Kaczynski

"Evidence Mounts on Role of Cigarette in Lung Cancer."

If I could zoom in. It is A3542.

"Millions of men will need all the will power they can muster to stop the habit unless the industry can find different tobaccos or more efficient filters to reduce the nicotine, phenol and tar content.

"One of the cigarette filters now on the market removes the phenols that are responsible for this adverse effect upon the cilia, and it decreases some of the other ill effects of smoke."

Mr. Anderson, this is an article in the Daily News about another chemical component of cigarette smoke before you ever picked up your first Salem; isn't that right?

A I'm going to repeat what I said before.

During that period of time, I read the sports, and during that time, I was reading about Martin Luther King and the civil rights struggle in the south. I did not see that article at that time.

C. Anderson-Recross/Kaczynski

Q Let me ask my question again, Mr. Anderson, which is -- this is another article in the Daily News about chemicals in cigarette smoke before you picked up your first Salem, isn't that right, sir?

A You said. I didn't see it.

Q Mr. Anderson, is it your testimony that you had no idea, before you picked up your first cigarette, that it might be hard to quit smoking?

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A Repeat that question?
Q Sure. Is it your testimony that before you picked up that first cigarette, you had no idea that it might be difficult to quit smoking?
A That is true.
Q Mr. Anderson, you have heard the term nicotine fit; haven't you?
A Yes, I have.
Q And you've used the term "nicotine fit," haven't you?
A Yes, I have.
Q Mr. Anderson, let me take you back to 1955. In is Exhibit A3483 in evidence, the Sunday news, February 13, 1955.
"Stop Smoking? They Said I Couldn't,

but I did!"
I'd just like to show you a couple of passages from that in the Daily News in 1955?
"For many years I had known that I should stop smoking. Time and again I tried. I guess I didn't have the will power."
And over here:
"Smoking establishes a craving in your body - Bantron" -- that's the product advertised here -- Bantron helps relieve that craving."
Mr. Anderson, were you unaware in 1955 that smoking might be difficult to quit?
A At 13, I wasn't even reading that paper.
Q Let's move along to 1957. Exhibit A3513. The Daily News, August 1st, 1957. At the bottom of the page is a story about a press conference that president Eisenhower had:
"Easy Way to Quit Cigarettes, By Ike. July 31.
"President Eisenhower today advised anybody who wants to quit the cigarette habit to think of something else and

avoid self pity while breaking off. 'If they follow that advice, they won't find it nearly as hard to quit smoking as they think it is."'
Mr. Anderson, you didn't know in 1957 that quitting smoking might be hard?
A At 15, I'm just like I was 13.
Q Let's move to 1959. You got married in 1960, correct?
A That's correct.
Q Here we are in 1959, a year before you were married. Daily News, May 5th, 1959. The title of the article:
"Club To End Smoking Uses Shock Technique."
I have a better copy here of the article itself:
"The physician president of the organization uses a shock technique to shake smokers out of apathy and encourage them to overcome the smoking habit. It

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goes like this: 'You are a drug addict. You obviously are suffering from nicotine poisoning and chronic respiratory inflammation. You are quite likely to

drop dead any old time.'"

Mr. Anderson, is it your testimony that in 1959, before you picked up your first cigarette, you were unaware that it might be hard to quit?

A I am unaware.

Q Mr. Anderson, you talked about sports. Was sports your particular area of interest in reading the Daily News?

A What period of time -- most of the time. What period of time are you speaking of?

Q How about 1959?

A '59? I'm still looking at the front part, the struggle in the south.

Q And sports as well?

A And sports as well.

Q Let me show you Exhibit A4296, Daily News, Friday, July 10th, 1959. Top article on the page says "Two Teams Tie at 66 For Baseball Medal" --

THE COURT: "For Best-ball Medal."

Q Thank you, your Honor.

"-- For Best-Ball Medal."

Then it goes on to describe a golf tournament.

That looks like the sports section; doesn't it, sir?

A I'm basketball and baseball.

Q Winged Foot Country Club? But right underneath there, "How to Stop Smoking Told By Top Athletes," and one of those two top athletes is Mickey mantle. Do you see that, sir?

A Yes.

Q When you were growing up, Mickey Mantle was a hero on the Yankees, wasn't he?

A Got that right.

Q This is a piece where Mickey Mantle gives his advice on how to stop smoking, correct?

A I don't know. I've never seen this article.

Q In 1959, in the sports section of the paper.

Is it your testimony that you were unaware that smoking might be difficult to quit?

A I'm unaware.

Q Now, in 1962, you had not yet begun smoking Salem cigarettes. I believe we established that earlier; is that correct, sir?

A Yes.

Q Let me show you Exhibit A4097. This is the New Amsterdam News, October 2nd, 1962. At the top of the page there's an article: "Kicking the smoking habit.

"As any smoker who has tried to break

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the habit knows, smoking is a powerful psychological and physiological addiction. Yet knowing what to expect, how withdrawal affects body, mind and soul, can vastly improve your chances of success and use of successful strategies can make the process easier."

Mr. Anderson, in 1962, is it your testimony that you were unaware that some people were calling smoking an addiction?

A I'm unaware.

Q Now, about 1963 is when you picked up your first Salem cigarette; isn't that right, sir?

A Yes.

Q Under your testimony; is that right?

A Yes.

Q Let me show you Exhibit A3678, New York Daily News, December 19th, 1963; article entitled, "You Can Stop Smoking, But It Isn't Always Easy."

"It is not always easy to stop smoking. There is no known drug or combination of drugs that can cure or overcome the tobacco habit or personally eliminate the desire for tobacco. It takes simple determination, backed by will power. Motivation helps considerably."

Mr. Anderson, is it your testimony in 1963 that you were unaware that it could be hard to quit smoking?

A That is true. I was unaware.

Q Now, in 1965, under your testimony, you'd been smoking a few years?

A Yes.

Q Let me show you the New Amsterdam News, Exhibit A4109, the New Amsterdam News, Saturday, May 29, 1965.

"Stop Smoking Program Set."

Mr. Anderson, you were aware, weren't you, in the 1960's, that there were stop smoking programs being advertised regularly in the New Amsterdam News; is that right?

A Well, during the years of '63, '65, I was

having marital problems. I wouldn't care what was out there. I'm going through some changes right now through marital problems. So I was not aware of this.

Q You didn't know about the stop smoking clinics in the New Amsterdam News?

A I didn't know anything. I'm having marital problems.

Q In 1965 -- let me show you Exhibit A4069, New Amsterdam News, Saturday April 24th, 1965.

And, by the way, can you take a look at the picture? It says: "Harlem Committee of Justice For Powell."

That would be for Representative Adam Clayton Powell; is that right?

A I can't make this out.

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Q Representative Adam Clayton Powell was involved in the civil rights struggle that you were reading about, right?
A Quite a few people was involved in the struggle.
Q But you said the civil rights movement was a particular interest of yours?
A Yes.

Q Okay. Right below that article, that picture, The Justice For Powell Committee:
"Stop Smoking Session Set;" and it discusses the Department of Health and Board of Education co-sponsoring a four-session stop smoking program.
Do you see that, sir?
A I see that.
Q Were you aware of that in 1965?
A I'm going to repeat. In '63 through on, I was having marital problems. My mind was consumed with my problems.
Q Continuing in 1965, July 10th, 1965, New Amsterdam news, Exhibit A4134, "How To Kick Smoking Habit." See that, sir?
A Yes.
Q In 1966, you were still smoking, correct, sir?
A Yes.
Q Let me show you Exhibit A4138. New Amsterdam News, April 16, 1966, "Schedule free stop smoking demonstration," and this time it's the New York City Health Department in cooperation with the New York City Tuberculosis and Health Association,

the New York Heart Association and the American Cancer Society.
Sir, you saw these articles in the New Amsterdam News and the Daily News, and they told you that it could be difficult to quit smoking; didn't they?
A I did not see those advertisements that you are speaking of.
I'll repeat. During the year of 1963 through on, I was having marital problems. My mind was consumed with my personal affairs.
Q Mr. Anderson, you used the word "nicotine fit," and you knew that to mean that stopping smoking could be a difficult thing to do; didn't you?
A I had a nicotine fit, yes.
MR. KACZYNSKI: Thank you.
No further questions, your Honor.
(Mark L. Bowin is replaced as Official Court Reporter by Diane Dorsey.)
(Continued on the following page.)

THE COURT: Counsel, go ahead.

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MR. FINZ: Good morning, everybody.
JURORS: Good morning.
REDIRECT EXAMINATION
BY MR. FINZ: (Cont'd)
Q Clyde, you were shown a lot of newspaper articles dated back to the 1956s and up until the early '60s. Remember that, sir --
A Yes.
Q Now, if the cigarette companies themselves including R.J. Reynolds, Philip Morris, and Lorillard had put any of the warnings on their packages that indicated that nicotine was addictive, would you have started smoking?
MR. KACZYNSKI: Objection, your Honor. This is duplicative of the previous redirect examination. That's the exact same question.
THE COURT: I will allow it however.
Q Would you have started smoking, sir, if they put warnings on their packages about nicotine being addictive, being a drug habit; being all those things?
MR. KACZYNSKI: Objection.

THE COURT: Counsel.
You want to answer, sir?
THE WITNESS: I would not have started smoking.
MR. FINZ: No further questions.
MR. KACZYNSKI: Nothing further, your Honor.
THE COURT: You may step down.
MR. GORDON: Your Honor, we need to get -- our witness is out in the hall.
(Off-the-record bench conference.)
MR. FINZ: At this time, your Honor, the plaintiff rests subject to the documents that still have to be decided and worked out by stipulation.
THE COURT: There is a -- number one was a document that is open and in our earlier discussion this morning, plus some records of other records, and you rest subject to those two?
MR. FINZ: Yes.
THE COURT: And each of the defendants separately are deemed now to have made a motion which is reserved

with a nunc pro tunc designation.
Is that satisfactory you all?
MR. SHEFFLER: Yes, your Honor.
MR. KACZYNSKI: Yes, your Honor.
MR. RANDLES: Yes, your Honor.
MR. GORDON: Yes.
THE COURT: Now, proceed.
MR. GORDON: Judge, we just need a very short break to get our witness.
THE COURT: Just walk out there.
We'll wait here.
MR. GORDON: Your Honor, defendants

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call as their next witness,
Dr. Elliot Fishman.
(Witness courtroom.)
D R. E L L I O T F I S H M A N, a witness
called on behalf of defendants, after
having first been duly sworn by the
Court Clerk, was examined and testified
as follows:
COURT CLERK: Give your name and
business address, first name and last.
Spell both please.
THE WITNESS: Elliot -- E-L-L-I-O-T,

Fishman -- F-I-S-H-M-A-N. And business
address is Johns Hopkins Hospital, 601
North Caroline Street, Baltimore,
Maryland 21287.
MR. GORDON: Good morning.
JURORS: Good morning.
DIRECT EXAMINATION
BY MR. GORDON:
Q Good morning, Dr. Fishman. I know you
just did so, but please reintroduce yourself to
the jury.
A My name is Elliot Fishman.
Q Dr. Fishman, are you a medical doctor?
A Yes, I am.
Q You tell the jury, where do you work?
A I work at Johns Hopkins Hospital in
Baltimore, Maryland for the past 20 years.
Q Can you tell us among hospitals and
medical school in the United States, how Johns
Hopkins ranks compared to other hospitals and
medical schools?
A Of course if you're at Johns Hopkins,
you always think it's the best; but in U.S. News
and world reports where they evaluate all

hospitals, Johns Hopkins finished number one for
the last nine years running, and similarly for
institutions in terms of medical schools. It's
either one or two for the past decade or so.
Q Doctor, where do you live?
A I live in [DELETED]

Q Are you currently married, sir?
A Yes, I am.
Q Does your wife work?
A My wife? Yes, she does. My wife is a
surgeon.
Q Doctor, where did you grow up?
A I grew up in Coney Island. I was born
in Brooklyn, actually in East New York, and then
we moved to Coney Island when I was small. I
lived on West 4th and Neptune by the train station
a couple of blocks from Nathan's.
Q Do you have any children?
A Two children. I have a girl who is 15
and a half, and a son who is 13.

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Q Now, sir, what are your current positions at both the Johns Hopkins Hospital, and

the Johns Hopkins Medical School?

A My current position is, I'm Professor of Radiology, and Professor of Oncology at Hopkins. I'm also Director of Diagnostic Radiology and Body CT at Hopkins.

Q You mentioned radiology. We're going to get into this in a bit more detail, but can you just tell the jury in detail generally what radiology is.

A Radiology is the subspecialty in medicine that uses X-rays or other means of imaging for diagnostic imaging of patients; and you know what? It's CAT scanning or MRI or ultrasound or mammography or plain X-rays or angiography. It's one of the largest subspecialties in medicine. It really began about 100 years ago with Roentgen discovering the X-ray and everything that's followed since then.

Q You mentioned the term -- was it diagnostic imaging?

A Right.

Q Can you tell us what that is briefly?

A Yes, in terms of what radiology is and what's called diagnostic radiology, typically how

I use the term diagnostic imaging is because we do more than radiology which tends to infer X-rays only. We do a lot of other things. Whether it's magnetic field imaging or ultrasound imaging, it's basically a field of medicine where you develop diagnostic tests for evaluating studying patients trying to detect the presence of different diseases, stage different diseases, helping diagnosis treatment and management of patients.

Q With my next question -- we are also going to get into this in much more detail for the jury, but can you just briefly tell us what the difference is in your view between a CT scan or what I think you may have mentioned is a CAT scan and a plain X-ray?

A Plain X-rays are probably -- a lot of people and the jury have had X-rays or family members have had X-rays. X-rays were discovered a little over a hundred years ago by roentgen, and what basically it is, it is in some ways very simple. It has changed over the last hundred years, but not a whole lot in the sense that if you have a source, an X-ray tube that would generate X-rays which go through, and then you put

the body part, let's say your hand in front of the X-ray tube or near an X-ray tube and there is a film behind you, then the information, the X-rays go through your body and will project what it sees onto the film. It's very good for certain things. It's good for example for bone, looking at bone and fracture, or typically how you diagnose

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fracture. It's not as good for soft tissues obviously. It's very commonly used for the chest. It's a reasonably good examination for looking at the lungs for example. CT scanning was actually invented or discovered, depending how you look at it in the mid to late 1970s by a company called EMI which is the company that actually brought you the Beetles, and actually the profit in the Beetles is probably how they come up with the process, through someone named Geoffrey Hounsfield and what you do in CT scanning.

The difference is that CT scanning in a sense is an X-ray but the difference is it's really a computer enhanced X-ray. So what happens and the way CT scanning was 20 years ago, it's changed some over the years as you may have seen. This is what happens. The patient lies really on

a table, and they go through a scanner which is -- kind of looks like a donut. You go inside the scanner, and what you have is -- you think about this donut and the circle. There are a number of detectors. What detectors mean is it's thing that gather information, and the X-ray tube will spin around your body, and information will go through all those detectors.

Some of the scanners now have a thousand different detectors, and then what happens is all that information gets sent into a computer, and the computer then generates an image, a very, very accurate image of the body. The difference -- you know -- again real briefly, is that when you image the person, instead of this picture of their whole chest, for example, you get a single slice, and typically your slice is about yay thin; two millimeters to eight millimeters.

Q Let me stop you for a second. We were actually, I think, going to do it later. Perhaps it may help the jury to do it now.

Have you prepared an illustration that may help the jury understand how a CT scan work?

A Yes.

MR. GORDON: Could we bring up for the Court and counsel -- I think it's X-1512? Your Honor, can I display that after you have a chance to look?

THE COURT: Yes. No problem.

MR. GORDON: Thank you. Can we bring it up?

Q Doctor, would it help if in the course of explaining how a CT scan works you briefly describe what we are looking at?

A Yes. This is actually --

THE WITNESS: Can I stand up?

THE COURT: If it helps.

A This is actually from an article we wrote. It's in some way a very simple -- just an illustration. Hence, here would be the patient just lying on the table. Behind them would be the equivalent of a detector, and here would be the

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X-ray source. The X-ray would kind of go through the patient, be detected here; but what you would understand is that it's kind of going around the body. So we would literally have maybe a thousand detectors, depending on the scanner getting all the information which would then be generated.

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The function of CT obviously is -- when you think about it, it's kind of a slice of body. It would kind of be the equivalent of either slicing bread or slicing salami; something of that equivalent.

And what you're really doing -- the thing about CT why it has become so important in medicine is because literally it's the equivalent of an autopsy in some sense, because if we did an X-ray, if I took a picture of you, if it was just say an X-ray tube, I would have the film behind you. I would take a picture, and everything that was you -- your bones, soft tissue, lungs, heart, everything that was you would project on that film in very good detail. When I do a single CT slice, I have a very thin section of you with all the different tissues separated. The thing about CT is that the way it works in part, is that different tissue types -- bone, air in the lungs, soft tissue all look differently.

So for example, I mentioned that Geoffrey Hounsfield was the person who discovered CT. In fact, won the Nobel prize in the mid-'80s for that, and the scale which is the scale called the Hounsfield scale.

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The way the scale is, you would say arbitrarily, that water is zero, bone which typically is white is plus 1,000. Air which is typically black is minus a thousand, and on that scale, soft tissue might be 70 to 100 different organs in the body or different densities. The one thing we are able to do is based on the density, based on the appearance, it is very sensitive for picking up disease, the presence of disease or the absence of disease. That's one of the reasons if you look across the country now, the use of CT scanning is probably growing at the rate of about ten, 15 percent a year.

MR. GORDON: You can take that down.

THE COURT: I thought that they were using MRIs as opposed to CTs.

THE WITNESS: MRIs had a lot of good press, and when MRIs came along in the mid-'80s, actually with CT and people saying, you're going to be out of business, and what happened is the change in CT just over the last couple of years have revolutionized a bit. At Hopkins for example, we do 45,000 CT

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scans. We probably do 8,000 MRIs. So it's -- you know. MRI has certain great advantages in the brain and spinal cord.

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THE COURT: That's what I'm used to.
THE WITNESS: Those areas, and if you do like a test for when athletes hurt the knee or a brain tumor, MRI is the way to go; but the rest of the areas for the most part in the body --
THE COURT: Normally, we see a lot of spines, MRIs, and I'm a little deflected at the moment.
THE WITNESS: Right. The spine -- if you see a lot of spines, for looking at the spinal cord, MRI is definitely the way to go; but if you are looking for example let's say at the abdomen, you're looking at the liver, the pancreas, the kidneys, looking at the chest, you want to look at the lungs, CT is the way to go.
THE COURT: Don't mind the personal interlude counsel. I apologize.

DIRECT EXAMINATION
BY MR. GORDON: (Cont'd)

Q You mentioned that besides being a professor of radiology at Johns Hopkins you were also professor of oncology?
A Yes, I am.
Q Can you just tell the jury briefly, what is oncology?
A Oncology is the field of medicine that deals with cancer. It deals with cancer in patients of all different types, and the physicians who are oncologists, if you say one is an oncologist, that means they're cancer doctors taking care of cancer patients.
Q I just want to spend a minute on your education. Can you tell us, where did you go to college?
A I went to college at -- I went to high school in New York, and then my family moved to Maryland. My father worked for the government, and I went to University of Maryland, College Park, Maryland.
Q What year did you attend that college?
A 1970 to 1973.

Q Was it that you finished in three years?
A Well, I finished earlier. At that point and now too you have a certain grade average and certain scores in your M-CATs, you can get accepted to medical school early. So I left college at three years and went to medical school, and they counted my first year of medical school and kind of a year of college, so I then got a college degree.
Q You mentioned M-CATs. What are M-CATs?
A It's an exam you take. It's like maybe like SATs in high school. You take SATs to go to college. This is a test you take if you want to go to medical school, and you get a certain grade,

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and that's one of the tests given. They give those tests to people because -- you know.

Let's say a grade point average at one school -- maybe an A at one school is not the same as an A at a different school. They try to give one test so everybody is kind of at the same level.

Q Did you receive a degree from the University of Maryland?

A I got a Bachelor of Science Degree.

Q How was it that you got admitted early admission to medical school?

A I had good grades, and I got high scores on my M-CATs.

Q Now, what years did you attend medical school?

A From 1973 through 1977 at University of Maryland in Baltimore.

Q Did you receive a medical degree there?

A Yes, I did; in 1977.

Q What, well let me ask you this. Did you continue your education after receiving your medical degree?

A Well, after med school you typically then specialize in an area, because once you finish medical school you can't do a whole lot actually probably. So I then --

THE COURT: It's like when you go to law school.

THE WITNESS: Right.

So medical students are very dangerous when they finish. You really don't know a whole lot, but about changing Band-Aids basically. Then you go into a subspecialty. I was very interested

in radiology. My initial interest was family practice, and I worked with two very good family practitioners doing my externship.

I worked with a doctor in Maryland, and I worked with a doctor upstate in Liberty, New York for a couple of summers, and both of those guys who had been in practice 25 years or so told me that if they could do it all over again they would go into radiology, and during my last couple of years I did some electives in radiology and really liked it and it was interesting, so I went into radiology.

Q Well, did you first do a residency?

A Right. You do a residency to -- I did a residency from 1977 through 1980 at Sinai Hospital in Baltimore.

Q What field was the residency in?

A In diagnostic radiology.

Q After you finished your residency, did you pursue any additional medical education?

A After I finished my residency, at that point what I did is fellowship which is considered like a post-graduate. So if you finish your residency, many people do additional training, and

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I did a year's training in CAT scanning, CT scanning which at that point in 1980 was very new, had been around for a couple of years; and yes, I was interested in that at Hopkins, Johns Hopkins. Dan Siegalman was one of the early --

THE COURT: Just one moment.

Q I'm sorry, the fellowship at Johns Hopkins?

A Right. I decided to do a fellowship. I also was accepted to John Hopkins to do a fellowship in CAT scanning with D. Siegalman in Baltimore.

Q Doctor, are you board certified in any medical area?

A Board certified in diagnostic radiology.

Q And what did that exam entail?

A In radiology then and today, what you do is take a two-part examination.

The first part is a written examination, typical written examination, and then if you pass that part -- it's about a 75 percent pass rate. If you pass that part, that's typically given like October.

Then the following June you would take

an oral examination, or you go to Louisville, Kentucky, and there are seven examiners which evaluate you in seven different parts of radiology. You pass that, you then get board certification.

Q Does everyone who takes that exam get certified the first time around?

A It's about typically it's about a 75 to 80 percent pass rate.

Q What about your case? Did you pass the exams the first time?

A Yes, I did.

Q Do you also have any licenses, medical licenses, doctor?

A In the State of Maryland.

Q I'd like to briefly run through your initial medical positions if you will.

After you finished your fellowship, what did you do next?

A First I was instructor at Hopkins which is basically the lowest level position in terms of staff then about 1981.

Q By the way, when you say Hopkins, I assume you're referring to Johns?

A Johns Hopkins.

And then I became an Assistant Professor of Radiology, and I was Assistant Professor of Radiology from like 1981 through 1986.

Then in 1986, I was promoted to Associate Professor; and then I was Associate Professor from '86 to '91 or so.

Then in '91 I was promoted to Professor which is kind of the end of line which I am now.

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Q What medical specialty was developed into these different professor positions?
A Well, it's all -- actually, I was radiologist, I was Professor, I became Assistant associate Professor of Oncology early in the late '80s; and then Professor of Oncology in 1991, approximately.
Q Do all associate professors eventually get promoted to a full professorship?
A No. Hopkins is -- different institutions have different rules. Hopkins has a very, very stringent criteria. Right now as professor at Hopkins, I have a pretty good field. Hopkins basically looks at people -- it has three

levels. We have three main responsibilities.
One we have is patient care. That's our most important role, is patient care.
Then we have education which is teaching residents, fellows, other physicians.
And then we have research; and what you have to do to get promoted is to excel hopefully in all of those areas. You have to not just excel, but you have to be recognized.
So to be a professor for example, they will send out between 25 and 50 letters to people who are in your field; not people you recommend, but people who they think are in your field then have to evaluate you. You need to have national and international recommendation as well to progress to professor. But the academic press, the publication, the presentation, all that kind of stuff, if you're lucky enough, you get promoted.
Q You are both full professor of radiology and oncology?
A Yes.
Q Are there any other radiologists who are both full professor of radiology and oncology at

John Hopkins?
A No.
Q And how is it that you also became a full professor of oncology?
A Well, in CT scanning which is what I do a hundred percent of the time basically -- probably 60 to 70 percent of our work is oncology related. So I work daily hour to hour with the oncologists, and the course of that is kind of like reward, I guess.
They offered me a position as Professor. You don't get paid for being Professor of Oncology. That's a secondary payment. It's an honor of this recognition, of the work you would have done and the work you do.
Q Tell us briefly what is a typical work week like for you. Take a Monday through Friday in the past month or so.
A Okay. Well, typically, use the five-day work week. Let's use that for a moment.
Do patient care, which is interpreting

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scans, reading scans, doing the scans about three and a half to four days a week roughly speaking, and then one day do one and a half days a week. I

do research or teaching or some administrative stuff.

Q What area of research?

A Research all in CT scanning. My areas of interests are imaging processes. Kinds of ways to making the scanners better, being able to extract more information from scanning. We do a lot of work with Three Dimensional Imaging.

We worked in the past 50 years with companies, that cutting edge of medicine which works initially with Lucas Films like Starwars movies. We worked with Pixar.

I don't know if you've seen Toy Story. We work with them in terms of using some of that technology for medicine. One of the things we find in medicine is technology developed in other fields can help patient care. We have done a lot of that.

I do a lot of educational research. So we do, for example, a lot of teaching. I have written books, articles, but now the best way to get information around to the people is to use the web. So we have a web site.

We have developed this web site, called

CT Is Us -- CTISUS.com -- and basically we have 2,000 different radiologists or so we have which log on from over 75 foreign countries, plus the United States. So we're very involved in education as well.

Q Beside the web site, are there any other computerized learning techniques that you've developed for other radiologists?

A We have developed -- we did a CD Rom. I did something called CT The Game MR. The Game is just educational CD Roms. We have done that. I've done probably ten or 12 video tapes like VHS tapes for educational purposes. I've done that. We do lots of -- I have done textbooks. We do lots of different things.

Q Can you tell us briefly, doctor, what percentage of your work that you say relates to patients being diagnosed for cancer?

A I would say that probably depending on a daily basis, 60 to 70 percent of all the work we do relates one way or the other to cancer patients; maybe even a bit higher.

THE COURT: I want to stop you for a second. I'm curious.

When you are watching Lucas and Pixar, you're looking at better film? I'm just curious.

THE WITNESS: What he did -- you know -- what happened is we have -- you know. You think about CT scanning.

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There are slices of information, but when you think about it like right now for example or even then, it was our concept that looking at each slice may not be the best way of looking at information; that if you looked at the entire patient at one time, the entire volume, you think about it. Each slice creates a volume, and so it was our thought or my thought that we should look at this.

I think I mentioned the image looking like 3-D imaging, particularly new ideas where in 1985 a chest CT for example would be 35 slices. Now, we do a chest CT, it's 250 slices because of computer technology.

So we thought that 3-D imaging would

be very good, and that at that point, Lucas developed a computer for Pixar. He developed that in order to be able to take an animate object and an inanimate object and make it look real.

THE COURT: So it was the computer, not the film.

THE WITNESS: Right, computer technology knowledge. So then we are looking to spin off this to do a computer company.

Then actually someone introduced me to them and they approached us to be the lead site, and they gave us all the equipment. We worked with them from about '85 to '91, and Steve Jobs -- Apple Computer who was actually the owner also owns Pixar. Now it's a public company.

He bought that from Lucas Films, and we worked very closely with them in early '90s. We were trying to figure out two big applications for their computer which was medicine, aerospace

and like --

THE COURT: So you've utilized that technique?

THE WITNESS: We still have the computers running. They were a little bit old. Now we utilize that; and in fact, that's been the core for everything we've developed since then, and all of our technology to date.

We have developed the brain 3D imaging system used in medicine helping impact on patient care. But it was all based on all that initial work, and in fact the technique is called volume rendering all the patents of users of Lucas films and Pixar.

THE COURT: Go ahead, counsel.

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DIRECT EXAMINATION
BY MR. GORDON: (Cont'd)

Q We spoke a moment about -- I asked you to walk through a typical work week. Let's take a typical workday. Also, let's say in the past 30 days, how many CT scans of different patients at Hopkins would you say you review on an average

basis?

A If I was there today, we would be doing approximately 70 patients.

Q Literally that would be scanned today, Monday?

A And then I would have looked at scans from the weekend or scans from the night. I don't know, ten or 15 scans, and then we were there all day long consulting, so I probably look at an average of let's say 15 to 20 outside CT scans; scans that weren't Johns Hopkins or done on Hopkins patients.

Q Let me stop you. So you're actually 15 or 20 on top of the 70?

A Right.

Q So this is really 85, let's say, being conservative?

A Right.

Q Can you approximate for us particularly in the past 12 months, how many CT scans you think you've reviewed in that time?

A I know certain things I'm very active on. For example, I know that I've signed my reports. It's about 15,000 scans, 15,000 patients

this past year. I have the one, the primary dictation on.

Q And how many of those would you say involved assisting in diagnosis of lung cancers?

A Let's see. I would say in terms of lung cancer we must look at 25, 30 patients; 30 to 40 patients a week. So let's say 1,500 to 2,000 patients a year, and they are very conservative numbers; probably a lot higher than that actually, But different patients -- we may see some patients three or four times, but --

Q Do you have any knowledge generally of how many CT scans radiologists among your peers review on an annual basis throughout the country?

A Since Hopkins has one of the largest volumes and staff, I would say just from prospective average radiologists typically don't --

MR. FINZ: Excuse me. I'm going object to this, your honor, unless there is some foundation.

THE COURT: Sustained.

Q Let me ask you this about the number of CT scans that you reviewed.

How are you compensated? I mean, are you paid for every single CT scan that you review;

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or do you get the same salary regardless?
A Hopkins, one salary. You get some bonus at the end. It's a small bonus. We basically get one salary.
Hopkins does not work -- it's not like a private practice where the more you read, the more money you earn. I get paid the same for three or five or ninety.
Q You mentioned part of your job entails lecturing and giving presentations; is that right?
A Correct.
Q And some of those are at Hopkins I take it?
A Right. There are a lot of different ways I do education.
For example, Hopkins is a teaching hospital. So when I read CT scans I'm not there by myself. I also have a fellow with me who is a person coming for one year to work with us on CT scanning; and then I also have a resident who is one of the junior trainees with me all the time. We read the scans together. I'm teaching them

constantly. So in a sense -- so in some ways, yourself looking, you are teaching 12 hours a day.
I also give lectures at Hopkins to radiologist residents and fellows, and also lecture nonradiologists and give lectures to oncologist chest people.
Q I'm sorry. What about hospital or medical schools outside of Johns Hopkins? Have you lectured at any other medical schools for instance?
A Right; yes. I probably give about 200 plus lectures a year when you look at it. I have lectured at many other medical schools this year at Mass General, Stanford, Duke, Michigan, NYU.
I was at NYU this past Christmastime approximately, Stony Brook, Albany. So I probably lectured at 50 plus institutions.
Q Have you lectured in countries outside the United States?
A I don't like to travel too much outside the state because of my kids and just the time commitment, but I was in France and Germany, and I'm going to Zurich in two weeks. I have been to Brazil. I have been to Israel to speak. I have

been to a number of foreign countries.
Q Has any of your work, doctor, involved assisting any government agencies.
A Right. I have been consulted by NIH, National Institute of Health which is the main, I guess, government body that has the funding responsibility for public health.
Q Does NIH have any mandate or responsibility for cancer research?
A Right. Part of the NIH probe or part of the NIH, National Cancer Institute, that's their function which is -- you know -- driving the research to find better treatments for cancer,

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detection of the disease, the whole spectrum of improving the care for the patients in the United States or people in the United States.

Q Are you a member of any professional organizations or societies pertaining to radiology?

A Yes. I am a member of a lot of societies, probably greater than ten. Some of them are very simple things.

Typical radiologists belong to organizations like RSNA, Radiological Society of

North America, or the American College of Radiology. But then I'm also a member of some societies where you have to be voted in or selected.

Like there is a something called the CT Society, TCLCTMR Society of which there is approximately 95 members now. The society has been around for about 24 years. I think I was the 36th member in the late '80s or something.

So I belong to all societies like a GI society where you have to get elected to a number of societies. I belong to the CTO. I'm the past President.

Q Are you a fellow in any of these societies?

A Yes. I am a Fellow of the American College of Radiology. I'm a fellow there, and that's something where you get selected if you've done contributions to radiology in terms of teaching or education or service. I was made a fellow a couple of years back.

Q Just to move through this as quickly as we can, I have your resume here, and it's somewhat sizeable; but can you tell us what involvement you

have had in publication of textbooks and/or textbooks chapters?

A Right. We have -- I have published. I have authored or co-authored about eight textbooks. The main one is Spiral CT which won the critics award of CT scanning.

We have had two editions, and the co-author of the book is Jeffery Stanford. We are in the process of doing a third edition.

I have written a number of books on CT scanning; probably written about 40 or 50 chapters for other people, textbooks both in radiology as well as surgery and oncology.

I have also written a number of articles in referee journals and nonreferee journals. I have written probably roughly 700 articles in the past.

Q Referee versus nonreferee. Is that a journal for peer review, and on the other hand, the nonpeer review publication, is that just another way of saying nonreferee?

A Right. Referee is peer review, and also you have to recognize in radiology for example or any part of medicine there are often many journals

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of many qualities. There are qualities of journals as well; but probably 90 plus percent of my articles have been referee journals, and it's -- sometimes they're nonreferee. You get invited to write things.

Q The textbooks you mentioned, who uses those?

A Typically radiologists or people in training in as radiologists.

Q Are you, yourself, or have you been a peer reviewer for any publication?

A Right. I'm a reviewer on the editorial board for probably 15 or 20 different journals for things like radiology, like the Journal of Radiology or AJR which is another big journal. I'm the reviewer for JAMA.

Q What is JAMA?

A Journal of American Medical Association.

I review for Journal Chest. I review for American Journal of Medicine. I review for surgery. On the average I would say I review one article a week roughly for somebody else.

Q How many cancer diagnoses would you say you've assisted in in radiology if you can

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approximate that?

A Well, I would say that if you look at it, I probably looked at over the last -- let's say this is the last ten years. I probably looked at 300,000 CT scans. 250, 300,000 CT scans. You figure that 60, 70 percent are cancer patients.

Essentially almost every cancer patient seen at Hopkins short of brain cancer I probably would have seen their films, and we see thousands of patients a year. So I've seen, 10, 20, 30,000 patients.

Q Does that include lung cancer?

A Yes.

Q Doctor, have you testified as an expert before or as a treating physician?

A I have testified as an expert witness.

Q How many times?

A I have been in a court like this, probably I think four or five times.

Q Has that been on behalf of both plaintiffs or plaintiffs' attorneys and defendants or defendants' attorneys?

A Yes.

Q Are you paid for your work on your

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medical legal work?

A Yes.

Q What is your current fee?

A $400 an hour.

Q Can you tell us -- what percentage would you say -- and you can take the past couple of years if that is easier. What percent of your annual income is derived or comes from testifying as an expert?

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A Well under five percent. Probably one percent.

Q We spoke a little bit before about CT scans and how they differ from X-rays. I now want to pause for a second on plain X-rays. Can you just tell us briefly how plain X-rays work?

A As I mentioned before, plain X-rays are in some sense very simple. You have a -- can I just get up there?

Q Sure, and I have a marker for you, I think.

A Make it real simple. Everybody can see. It's in some senses very simple. You have a source of X-ray. Is the X-ray tube here, I think, with the patient or body part.

Let's say you have someone's hand here, and you have an X-ray film here, and the X-ray goes through the patient, goes here, and you X-ray an image for something like let's say your wrist, that works very well, because all you want to see is the bones.

What we will typically do is if you have got an X-ray and you're worried about the fracture, they just don't do one view like that. They will do three different views, because if you think about it, you can have a fracture or dislocation. If you only got one view, it's hard to see.

If you see about somebody's chest, you think about a patient -- I'm not a great artist. Here is a head thereabout. You do a chest X-ray, you have an X-ray tube here. You take a picture of your chest and put it on the screen and create an image. That shows basically everything that was you which would be your lungs, your heart, your bones, and it creates that on obviously a flat piece of film.

You might get two projections, but the limitations of plain X-rays -- A, it's very simple

and relatively cheap, but the limitation is in how it's acquired.

When you think about it if I'm taking a picture of you and everything that is you and putting it on a flat film, everything overlaps, so the detail of what exactly is going on, the specifics, the finding details just is not there; but chest X-rays are very good, and in fact for 80 years that was the goal standard for looking at, being able to look at somebody's chest for example.

As I mentioned with CT scanning, it's not quite like that. So the CT scanning, you think about it. Here is a machine. The patient lies on a table, and the machine, and you take this beamer. So if you have a patient, what you're doing is you're getting slices of the patient.

In fact, now we can get hundreds of slices of you, but what happens instead of imaging

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everything, we get an image which is a slice of your body. So for example, if there were you, we would see your heart, we would see your spine, we would see all your ribs, your lungs, we would see

your blood vessels, and it's literally a slice. It's a human autopsy, because we are basically getting a slice of your body. And of the many articles published, throughout the literature we have published, other people have published basically shows what you see on a CT scan, and what you would see if that patient went to surgery, and an autopsy is literally one to one. It's -- a CT is the most accurate study of what is here is. What you see is really what's there.

MR. GORDON: Doctor, thank you.

THE COURT: On a break, folks.

(Jury exits courtroom.)

(E. Spielman relieved D. Dorsey and recorded the proceedings.)

* * *

DIRECT EXAMINATION

BY MR. GORDON:

(continued)

THE CLERK: You may be seated.

(Jury enters the courtroom.)

Q Doctor, you're all set to proceed?

A Yes.

Q Before we took a break, I think you were illustrating how x-rays worked for the jury. I now moved the chart over here so you could view better.

Can any doctor review and interpret x-rays whether they're radiologists or not?

MR. FINZ: Objection.

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THE COURT: I'll allow it. Why not?

A The reality is that any physician, licensed physician, could look at and theoretically read x-rays just as any licensed physician including myself could do brain surgery or cardiac surgery.

I don't think you want me to be doing your cardiac surgery.

MR. FINZ: I object to anything beyond that. I ask it be stricken.

THE COURT: One moment.

But isn't the diagnosis of x-rays more

relevant in certain areas?

THE WITNESS: Yeah. Definitely. Radiology I think the reason we've grown so much is because it has impacted on all specialties.

But I think the important thing to recognize is you take myself or any radiologist Board certified radiologist we finish med school, typically do a year of internship and then spent five years just doing radiology. That's all we did is spent five years doing radiology.

THE COURT: I don't wish -- I understand each specialty has its own thoughts on the subject. But we've heard testimony from others saying that by the nature of their specialty, whether it's pathology or oncology, the use of the x-ray is a major tool for their practice.

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THE WITNESS: Undoubtedly that's a hundred percent true. But, for example, my wife is a surgeon. And CT scanning is a very important part of surgery.

Every patient she operates or sees she looks at the CT scan herself. She would never consider looking at the CT scan or look at the x-ray report.

MR. FINZ: I will object to anything that his wife will do.

THE COURT: I'll allow it.

A Any surgeon I know who practices, I would say it's malpractice to operate on someone without looking at the appropriate studies.

THE COURT: For him.

THE WITNESS: Or her.

Even if the radiologist interpreted it, which they did, you have to look at it before you operate to treat the patient.

But, on the other hand, a physician, a surgeon would not consider that they're the primary reader or reader themselves and make the decision to look at the radiology report speak to the radiology.

But with radiology, it's like a lab report in a sense. You're ordered to look at it, but you

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would never consider that you're the primary reader. We have for example --

THE COURT: I understand. Okay.

Q Well, picking up on that point. Let's talk about pulmonologists, for instance, who do have some involvement with the respiratory tract.

The jury has heard from Dr. Feingold. Are you aware from Johns Hopkins what involvement, if any, pulmonologists have of interpreting CT scans?

A Pulmonlogists do not have any specific training in CT scans or chest scans. But look at them. Everyday I would say they --

MR. FINZ: Objection, your Honor. Now --

THE COURT: Sustained.

Q Getting back to the difference between x-rays and CT scans, that is, what one could see inside the body using one verse as the other.

What can you -- what can you see in the CT scan generally that you can't see in an x-ray?

A Let's just -- let me give you an example, the way of looking at it.

If I had a hundred patients who had a two centimeter or three centimeter mass in their lung and I do CT scans on all hundred patients, I would see the mass 100 times.

If I did a chest x-ray in those hundred patients, I would see the mass only 70 times. So that's a

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good way of looking at some of the numbers. The accuracy of CT and x-ray is substantially different. The way to look at a chest x-ray would be first approximation.

Whether you're looking at infection of the lung, whether you're looking at tumors in the lung or any other process CT by its nature the fact that you're getting individual thin slices without the problem of overlapping structures because of its detail is the most accurate study.

CT scanning is the gold standard, of course, the wide range of pulmonary disease.

Q The jury has heard a paramount amount of testimony including the parts of the lungs such as the bronchus or bronchi.

Are there aspects of the bronchus or bronchi you could see as far as their definition on a CT scan you couldn't see on an x-ray?

A Sure. If you think about the airways, it might have been explained before. When you have the trachea, which is the long tube that comes through the chest --

I could draw it if you want?

Q Sure. Why don't we do that.

A It's the way to think about it. It's sort of relative to how much you can see.

If you think about the trachea is the main airway and it branches into tubes. This would be the right

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side of the patient. This would be the left side.

If you look at a chest x-ray and it's a good quality chest x-ray, you would see the area, the trachea, very well.

But on CT, these branches are actually ten different segmental branches, three upper, two middle, five lower. I could see all of that on CT scanning. You would never see them on a regular x-ray.

So the detail, the localization, the process of any disease process is all going to be seen better here.

As I mentioned about the nodule, looking at it there was a study done in Cornell.

MR. FINZ: I object. He's going far beyond the question.

THE COURT: Let's go on to --

MR. GORDON: Okay.

Q What diseases, for example, can you identify in a CT scan?

A If you take the chest again, just to be more specific, you can look at anywhere from the lung parenchyma, which is the tissue of the lung, looking for infection, bronchial emphysema, the presence of lung masses or nodules.

If you look at the central part of the lung,

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which is called the hilum, look at the central airways, you could look at the heart. You could look at the parts of the heart, the pulmonary artery. For example, nowadays, we think of pulmonary embolism.

Q Doctor, is it possible with a CT scan to, for instance, determine whether a tumor in someone's lung is cancerous or not?

A Yes. I think the way you look at a CT scan is we do several things. The first thing is the detection of the disease.

So if I told you I saw a mass in someone's chest, you might think of cancer. But there is a lot of possibilities. So the first thing is detection of disease. And whether it's your chest or your brain or your abdomen, the first thing you do is detect disease.

Then one of the things we've learned based on our experience and the published literature and other people's experiences that diseases have certain signatures.

So, for example, if I had a lung mass what do I look at, the size, the location is it to the bronchus or not. I look at the presence of the density. Is it calcified.

If the mass is calcified, that means it's got

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calcium in it. That means it's a granuloma. If the mass has fat in it, it's something called hamartoma.

So with the CT not only do we detect disease, that's the first step. We could be very specific in diagnosing exactly what the lesion is. That's why it's a very strong tool.

In CT scanning you get all the other information that changes. Often we will look at a lesion it will be sent to us for possible cancer. We'll be able to say this is hamartoma. Sixty percent is hamartoma. That's fat. Do nothing.

So it's very very critical as a radiologist for the patient care not just to detect something wrong. Just to say there is a mass in the chest means nothing. What is it doing? What's the involvement?

Q There are different locations in the lung where tumors can arise?

A Tumors can arise essentially anywhere in the lung. The way I like to look at things, I look at its relationship with the airway. Is it involving the airway? Is it involving the chest wall?

Q Let me stop you for a second. What is "parenchyma"?

A Parenchyma is the lung tissues. When you think

about the lung, some of the lung you can't see on a chest CT or chest x-ray because it's microscopic.

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When you think about these airways, they keep branching. You can't see them below two millimeters. They keep branching. The smallest alveoli, that's where the air exchange takes place. You could see where exactly the involvement is on a CT.

Q Is one way to differentiate where tumors occur to call them either essential or peripheral?

MR. FINZ: I might object to the leading question.

THE COURT: Counsel, sustained.

Q Have you ever heard of the term "central" in connection with where a tumor is located?

A There is a number of different ways of describing tumors. Some people like central or peripheral. Central, meaning it involves central airways of major bronchi, major airways, major tubes of the lung, with peripheral being somewhere in the lung tissue away from the central areas.

Q With central, with this sketch you've drawn up here with the tumor, are you saying the tumor would involve one of these structures?

A It could have been one of those or one of the major segmental branches.

Q Is it the case that different lung tumors or types of lung tumors appear differently in the CT scan?

MR. FINZ: Objection.

THE COURT: I'll allow it.

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Q You can answer.

A Yes. As I mentioned, there are -- you take lung cancer for a second. There are a number of different ways of lung cancer.

What we like to say is that the diseases have signatures. They have certain appearances. There is something called the small cell lung cancer. Invariably, the way it looks you'll see a lung mass, a couple of centimeters and then within the middle part of the chest you'll see adenopathy spread. Spread occurs toward the lung apex. Something called a Pancoast.

Q Doctor, can you just slow down a notch.

A Sure.

A Other tumors occur in the airways themselves. So, for example, things like hematomas, things like carcinoid tumors can be more central. Theoretically, lung metastasis can occur in the airway. So lesions have different appearances.

Q In connection with the work we've asked you to do in this case, have we asked you to review chest x-rays and

CT scans of Mr. Anderson?

A Yes.

Q And did we also ask you to review written reports related to those x-rays against CT scans?

A What I do is someone asked me to look at a film I look at the film. They ask me -- I wanted films. And that's it.

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Q Can you tell us were there any particular films that you can recall that were helpful in arriving at your opinion in this case among Mr. Anderson's CT scans or x-rays?

A Right. The x-ray obviously showed a mass. But the main study, the information is the CT scan from, I guess, 6/8/96 or 4/8/96.

Q April 8th, '96?

A Yes. April 8th.

Q Let me show you what's been marked as Defendant's Exhibit A 4405 for identification and just ask you if this is the CT scan that you were referring to.

For the record, this film, I think, was also introduced by plaintiffs during Dr. Finegold's.

THE COURT: We don't want two numbers. Let's refer to it by Plaintiff's Exhibit whatever.

MR. GORDON: I'm not sure if it was marked

into evidence.

MR. LONDON: It's in evidence.

MR. GORDON: We can do that. In that case I think it was, Plaintiff's 468-B.

THE COURT: In evidence.

Q Okay?

A This is one of the sheets of film from that study from April 8, 1996, the most current film.

Q We have this contraption here. I think it's

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called a light box or a view box. Would it be helpful in reviewing that film if we put that film in here and ask you to come down?

A Sure.

(Whereupon the witness approaches the shadow box.)

THE COURT: Could we please have some help, please, folks?

Q If it would help, can you start by telling us what parts of the body we're looking at in whatever images you want to use for illustration purposes?

A Just to show you, just to do it very briefly: This is a series of images, one, two and you can see there are 12 images here.

This is 12 coming out of 40 or 50 images done

of the patient. What you do is you look at each of these images.

If I look at the parameters, what I can tell you is each of these images is ten millimeters thick and they're all separated by about eight or ten millimeters.

And the way you look at it, you take let's say we're concentrating on one image here which is image number 12. You look at this image, the first thing is orientation. That's the interior. This is posterior. That's the chest wall and that's the spine back here. And this is right and this is left.

As I mentioned before, there are different

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scales, things different in the CT. One is the lung. You can see black here. That's the lung or anything there is black. And soft tissue tending to be white.

You can vary that a little bit because when you look at the scans because it's a computer image and the reason you can see good is we're able to change the parameters on the scan when you're looking at it to see.

When you look at things this way, it's with the lungs and airways best. I can take the same image and it's something else called a soft tissue window which would not be the lung in the same detail but would give me a better appreciation of the vessel.

Over here is the ascending aorta, the descending aorta. Those are the pulmonary arteries. You could get a feel of this.

What I do is when you look at the scan, you're able to concentrate only on this image is what am I looking for. What I'm looking for normal anatomy . And then I'm looking for anything that might not belong there.

Some things may be normal variations. People have normal variations. For example, typically your aorta blood vessel is on the left side, comes out on the left side.

On some people it comes out on the right side. There are possible variations. Then I look at other things. When I look at the study, the scan, I look at

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someone's lungs, I look at the size, number, I look at the airways, I look at the hilus.

I look at the soft tissues in the wall. I look at bone. The reason CT is a strong disagnostic tool is because in one examination today, this study took -- this is a scanner, this probably took the patient two, three minutes to do.

Now the same study literally four years later it takes literally 20 seconds. Nevertheless, you look at the study and look at all the information.

In this test what I'm looking at is in order, if I start with this image the first thing I see the black spot that's the airway.

The black that's the lung. That's the trachea. That's the main tube I was telling you about, and we're following it downward. There is another structure down there which has air. That's the person's esophagus.

So I would worry about it. Some people have air in the esophagus. It's most common when someone has a reflux hiatal hernia. You swallow and get air in the esophagus. That's not important. That's not uncommon.

Let's say I look at the airway, so now I'm coming down. The thing the CT does, the way of looking at it. We'll concentrate on the airway. I'm creating a roadmap. I'm looking at the main area, the trachea.

Then the trachea bifurcates. That means it splits in two ways. For example, if I was what typically

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if you thought about, let's see if I can move this and we can see this if you think about what we're doing.

What's a CT scan? I'm getting slices. Those are my slices. Okay? Here are my slices. That's what I'm doing. So, for example, this image over here is about right here. That nice airway. The airway is a circle. I go here.

I'm now looking at what's called a carina with a bifurcation out of this scan and things are now splitting into two. Then I go a little bit further and now what I'm getting is the right main stem bronchus which is kind of to this point.

What you see here with this image, I see the bifurcation. I go to the next image. I now see the patient's right bronchus, the right main stem bronchus.

What I will do here is -- let me just draw a schematic relevant to that image. Let's see what happens here. This is that here. If I do it this way, here's the right main stem bronchus. You go into the right main stem bronchus.

You go straightforward. That's the interior part. And if you go here, that's the posterior. There is three segments in the right upper lobe. So although this is called the right upper lobe, these three segments the middle lobe you go lower there are two segments and you see really on the lower scans that's the lower scope branches

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which is five different branches. Ten branches to the right ten to the left.

The thing about CT -- you can't see the branches on the x-ray. On CT it's very obvious with training where the branches are.

In this case, you could see what's abnormal is not very difficult to see from across the room is there is a mass here.

There is a mass. I could tell you how large the mass is. Again, the CT is very active because if you look at the sign here. I don't think most of you could see it.

THE COURT: We can't see you. We can't see the picture.

A You have to have one of the projection view boxes. But on the side of the scale is a thing like this. There is a scale, one, two, three, four, five.

Q Are you referring to something that looks like a ruler?

A A ruler.

Q On the side of the CT images?

A I could be very accurate in terms of size. So, for example, if I took a little marker and measured how big this was and put it over here, I would say it's about I measured before it's about 4.9 centimeters.

We could be very accurate. Not only could I see the mass, if I looked at the other images, I could tell

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you the mass was not calcified. There was no fat in the mass. The mass is relatively smooth. Or, I could tell you

where is the mass. The mass is engulfing the bronchus over here. It's an amputation of that bronchus as you see with the lesions.

Let me just show you something. One of the things that we can do is if you think about an airway and in a sense an airway if I could move out of the way, an airway is nothing more than a tube.

What we do is we -- all of us breathe and it's just the tubes that allow the tube to get in air to get in and out of the tube. This is a very important thing. We mentioned before tumors typically arises in the airway.

If something arises in the airway, a tumor grows, and it grows something like this, and then you see the airway and you see it's amputated and you often see this curved sign.

Airways can be involved by tumors secondarily. If you have a mass growing over here, don't compress the airway as well. You can see how it's growing. It's compressing this way. So it kind of tapers down.

So one of the good signs in distinguishing whether something arose in an airway or adjacent to an airway, it's a very subtle thing, you couldn't be sure on a

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plain film but on a CT scan. That's why CT is so good. I can show you on this.

Q Let me stop you for a second. Just picking out on this illustration: Is it possible for you to determine from one of the CT scans as to whether the tumor that Mr. Anderson had started in the bronchus and grew out into the parenchyma or the meat of the lung, where conversely it started outside and grew into the lungs?

A Yes. Because if you look at it again, I can't blow it up, you see if I drew it, I'll use more paper.

THE COURT: We'll find more.

A Some day they might be worth something, those papers.

If I showed you, I will draw this picture here. Here it comes this way, this and this. So basically here is a patient's right bronchus. Here is going to be the upper lung. Here is where the tumor is.

See the tumor here is the posterior bronchus. You could see how it's patent until it gets a meniscus cutting it off, amputating it which means it arose inside the airway.

There is no atelectasis which means compression of the lung. So, for example, if I had a tumor outside the airway involved secondarily it would compress

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it down and you would see the not only the mass but also obstruction of lung tissue beyond the mass.

One of the things to recognize the reason CT is helpful in terms of management of the patients, you could imagine if I was home doing this on a real patient what we would do is not only describe a mass, say here is a five centimeter of mass, right up the lobe, posterior segment right up the lobe, but it's arising right up the airway. You need to biopsy the mass.

Q Let me stop for a second. "Bronchoscopy", what is that?

A Bronchoscopy is a technique where you put a tube literally down the airway and you're able to go into the airways and you're able to look in the airways.

You're able to typically biopsy something. You could biopsy what we call percutaneously. For example, different lesions we biop different ways. This patient with a biopsy going through a bronchoscopy, there is no right approach for which is best.

When you think of bronchoscopy, it is kind of equivalent to this pointer. What you would do is come down. Here is the big airways. You would kind of come down you would tell a bronchoscopist go into the right lung. You follow it down. You see how far it's going.

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You go into the airway, go right into the right instant bronchus, then go straight and then about three and a half, four centimeters in make a left turn.

Make that left turn, you're going to run into a mass, biopsy that mass, and you'll have the answer.

So in a sense one of the reasons before we're discussing about CT scanning and pulmonologists they look at the scan, because if someone did a bronchoscopy and didn't look at the scan, they would do a disservice to the patient.

By knowing the roadmap, 30 percent of the time they don't get an answer. But here if I tell you, you go in, go into the right, go straight, make your first left turn, boom here is the mass, you're not going to have a problem.

Q Let me ask you this: We spoke before you got off the stand where tumors arise on the mass, that is, central versus peripheral.

Can you tell us what significance, if any, there is as far as location of Mr. Anderson's tumor, the tumor he had removed given this tumor was encasing or involving the bronchus?

A Right. I think when you look at this mass here because of how it creates this kind of interface to the

airway, my thought would be that this mass arose in the airway at some point.

Now, the thing about that is that you think

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about different tumors.

MR. FINZ: Excuse me. Your Honor, what is the significance?

I'm going to object unless there is a specific response to that question.

A The significance is depending where something arose the likelihood of what it ends up being would be affected.

So statistically if you tell me a lesion is in the airway or arises in the airway, I would give you my four best suggestions of where the mass is. If you tell me something does not arise in the airway but arises in the purview I would give you my four possible choices.

MR. FINZ: I'm going to --

THE COURT: That's a good spot. Next question.

Q We were talking about the biopsy procedure. Have you ever heard of a term "endobronchial lesion"?

A Endobronchial lesion is a lesion extending out of the bronchus.

Q In the course of performing your work on this

particular case, did you have a chance to review the biopsy note pertaining to Mr. Anderson?

A Yes, I did.

Q And can you tell us what if anything that note indicated about whether they have an endobronchial lesion?

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A The bronchoscopist report said he did not find any bronchial component.

Q How do you account for that, if at all, based on what you're telling us was the location of Mr. Anderson's tumor?

A I think you can really understand what exactly happened simply by looking at the film. If you see, the bronchoscopist would come down. You would be in the right main stem bronchus. You would be right here. You would come down.

MR. FINZ: I'm going to object to this as not being responsive to that question. Now we're talking about something else.

THE COURT: I'll allow it.

A No, I'm going to explain to you you, go right in the bronchus, you travel down. And so what happens here it's traveling down the tube or the highway. And if he went straight, then let's say we were right here, you see this, if you're standing right here, if this is the way

he's traveling, if he's in the area here, the tumor is like here. He biopsied here, about the tumor. You see if you're standing -- let's change this. If you come down the airway.

MR. FINZ: If your Honor please, I'm going to object to it being speculative.

A I could explain.

MR. FINZ: Please.

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MR. GORDON: I think he's in the course of answering the question.

MR. FINZ: Could we have the question, please?

THE COURT: One moment.

Don't speculate as to each way it traveled unless it is in the notes.

MR. FINZ: Thank you.

A He traveled down the right main stem bronchus because that's the only way it could travel. That's what he said anyway.

If you come down here, let's say you were at this point, any of us were at this point as you can see on the x-ray here, if you look straight ahead, it's clear sailing. There is nothing in the airway. And that's how he looked. Unless he would have gone --

MR. FINZ: Excuse me, Judge. Please, I'm going to object to this and ask it be stricken.

THE COURT: Sustained.

MR. FINZ: Because he has no way of knowing.

Q Don't answer any further.

Let me ask you this, Doctor: You've done a number of illustrations. Have we, in fact, had an illustration prepared that would help illustrate the location of the tumor that Mr. Anderson had?

A Yes.

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Q Let me just get that.

I believe we faxed this to you over the weekend in a much smaller size. Just put this up on the other leg sticking out.

A This is not quite as good as my drawing, obviously.

But you can see what we're saying is here is this patient's -- I can draw on this side. Here is the airway. Here is the main stem bronchus. Here is the black where the tumor is involving the posterior segment to the right upper lobe. That's exactly if you think about it this way. Here is the tumor in the right upper lobe.

MR. GORDON: Okay. Judge, I don't want to take up time doing this now. Can we mark this as

a defendant's exhibit?

THE COURT: Yes, we'll deem it marked.

Q I believe you may have mentioned this before, but is there a way that you can estimate based on the CT scan or any of the other records that what was the size of the tumor that Mr. Anderson had removed?

A We don't have to estimate. As I mentioned before, there is a very accurate scale here. Remember this is generated by a computer, this grid or ruler here, and I can simply use the ruler to measure. It's approximately 4.9 centimeters. It would be very accurate.

Q What is, for the purposes of diagnosis, what significance, if any, is there that the tumor was that

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size?

A Well, you know the first thing to think about when you have a larger tumor if it's malignant is that some of these five centimeters there is a good chance it probably would have spread already. That's one of the things to think about already. Because cancers and their extent of disease is related to size because typically the bigger something is the longer it's been there.

One of the ways we also stage tumors. There is something in oncology called TNM. All patients are staged that way. That stands for tumor nodes metastasis.

If we look at a patient, for example a, T would have been lesion, let's call it T-1 is under three CM.

Q CM?

A Centimeters. Over three centimeters is typically what's called a T-2 lesion. The reason that's important the tumors, the nodes and metastasis what we try to do is stage everyone the same way so that we could treat people the same way.

So your prognosis is based on your staging, for example. So size becomes an issue. The other thing, certain lesions tending to be larger than other things. Certain lesions I talk about. Like adenosquammous carcinoma. If you tell me adenosquammous carcinoma, the average size, I would say is two centimeters which is about an inch.

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MR. FINZ: I will object to all of this. It's far beyond the question itself.

Q The original question was?

THE COURT: Is there any reason why we need to stand over here? We have it on the board.

MR. GORDON: No, we have it on the board.

Q Doctor, are you aware from your review of the records and x-rays and CT scans that you reviewed in this case whether Mr. Anderson's cancer spread or metastasized?

A I am aware from both his initial CT scan which I reviewed which showed evidence of tumor spread. I also looked at some other studies including a scan from February 2000 which showed evidence of a surgery but no evidence of any tumor.

Q Was the February 2000 CT scan, the latest CT scan, of Mr. Anderson that you reviewed?

A To my knowledge, yes. With what I reviewed, yes.

Q Are you familiar, Doctor, of the term "differential diagnosis"?

A Yes, I am.

Q Can you tell us briefly what that term means?

A Differential diagnosis is it's a way of describing the likelihood of what something is. So, for example, if I said to you a patient had a lung mass and you said to me how many things can you name that cause a lung mass, I could probably name a hundred.

But that would probably would do you no good

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in taking care of the patient. What differential diagnosis is is considering all the possibilities that exist considering what the radiology study shows and saying what the most likelihood one, two, three or four most likely diagnoses are.

THE COURT: Wait a minute. And that's what a

radiologist does?

THE WITNESS: That's what we do.

Because if I were just to say to you, which some radiologists do, which is not very helpful it's one of the 30 possibilities, I would not be a very good radiologist. I wouldn't help any.

Q And my next question is: Did you generate a differential diagnosis after your review of the CT scans and x-rays of Mr. Anderson?

MR. FINZ: May we approach, if your Honor please?

(Whereupon, a conference was held at the Bench between the Court and Mr. Gordon and Mr. Finz.)

Q Doctor, within a reasonable degree of medical certainty, did you generate in this case after your review of Mr. Anderson's CT scan and x-rays a differential diagnosis pertaining to the tumor he had removed?

A Yes, I did.

Q And can you tell us what that differential

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diagnosis was that you arrived at?

A The first thing, obviously, any time you have a lung mass, you consider cancer. That's no surprise. But because of the size of the tumor, the location of the tumor

where it appeared to --

MR. FINZ: I will object to all of this as not being responsive to the question.

THE COURT: Overruled.

A So here is where I got my differential diagnosis. I looked at the size of the mass and its appearance. It was smooth and lobulated. There was no --

Q What does lobulated mean?

A It's not like sharp edges. It's sort of smooth edges. It was relatively well-defined mass, approximately five centimeters.

Because of its relationship to the bronchus, the posterior segmental bronchus, it was my opinion it might have arisen from the posterior segmental bronchus.

I looked at the media stinum. I looked at the hilum. I saw no evidence of any cancer spread. And out of the five centimeter mass, you still consider cancer as carcinoma but you look at the other things.

If you have a cancer of five centimeters and there is a squamous cell, which is one of the two of the types of cancers. You will typically have nodes or tumor in the media stinum or hilum. I didn't see that.

Because of where it was, it was -- it's not

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at this point typical of an adenocarcinoma or a squamous

cell carcinoma or small cell carcinoma or large cell carcinoma.

So I begin to think of things that would have arisen in the airway. I might think of a carcinoma tumor, one possibility and adenoid cystic tumor as a possibility.

So to me looking at this case, the one thing I would tell the referring physician, it's not your typical cancer case. There is something atypical, the entire picture.

And that's what my differential diagnosis would be looking at the findings. This is not your typical cancer case. It could be one of the more unusual tumors.

One of the things you don't want to come up with is quasi-diagnoses. You want to be logical.

That's why you go with experience. You be logical with the most likely choices. That's what I would alert to them.

Q I have a hypothetical for you. This jury has heard a number of hypotheticals over the course of the trial.

I want you to assume, Doctor, that there has been a Board certified pathologist in this case who testified that after reviewing Mr. Anderson's pathology he believes the type of lung tumor that Mr. Anderson had was

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known an as an adenosquamous lung tumor. Would you assume that for me.

I also want you to assume that there will be another Board certified, equally qualified pathologist, who will have reviewed Mr. Anderson's pathology and will testify that he believed Mr. Anderson's tumor was the type of lung tumor known as a mucoepidermoid.

My question for you, sir, is based on your review of Mr. Anderson's CAT scan and x-rays, do you have an opinion with a reasonable degree of medical certainty whether the tumor that we've looked at this morning was more consistent with an adenosquamous or a mucoepidermoid?

MR. FINZ: Objection. No foundation.

THE COURT: Overruled.

A Because of how I know adenosquamous look like and because of how I know what mucoepidermoid look like, I would say it's more consistent with the mucoepidermoid. I would agree with the second pathologist.

Q What do you base that opinion on?

A If you think of adenosquamous, it doesn't involve the airway. Here I'm thinking all along of the lesion that arose in the airway. That is what mucoepidermoid does. Just, coincidentally, there was an article published this summer that had very similar pictures.

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MR. FINZ: I object to that, if your Honor please. I move that that be stricken.

THE COURT: Is that article scientifically acceptable?

A That article was published in the journal called "Radiology" which is the number one --

THE COURT: Do you consider that authoritative?

THE WITNESS: Yes, I do.

THE COURT: You may refer to it.

MR. GORDON: Thank you.

Why don't we bring up X 12128 just for counsel and his Honor and the witness, of course.

Q Doctor, do you have something on your screen there?

A Yes, I do.

Q Can you tell us is that the article that you were just discussing with the jury and the judge?

A Yes, it is.

Q And are there any pictures, CAT scan pictures or otherwise in this article that you found helpful in arriving at your opinion that Mr. Anderson's tumor appeared like a mucoepidermoid?

A Probably in the third page of that article.

Q Let's try X 12122.

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THE COURT: Is that what you're referring to?

A Yes, it is. That sequence of images.

THE COURT: Okay.

Q Is that the page you're referring to?

A That's the page.

Q Can we turn that on the side, perhaps?

A If you look, there is four images.

MR. GORDON: One second, Judge.

Can we bring that up for the jury?

MR. FINZ: I object to that, Judge.

THE COURT: Overruled.

MR. FINZ: May we have a voir dire on that, your Honor?

THE COURT: No.

Q Doctor, is there -- well, first this is the article from the publication "Radiologist" you're referring to?

A Right.

Q Have you ever had articles published in "Radiologist"?

A Yes, I have.

Q Have you served on the editorial board of Radiologist?

A I was one of the associate editors.

Q If you could get up, if it helps you if there is a particular image from that article that you found helpful that he had a mucoepidermoid?

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A This lower quadrant portion of the image you could see again just for the jury that the resolution kind of loses something when you take it from an article. If you see what the mass is kind of almost the same size of the mass. You see how the airway comes just like this case. Here is the airway. Here is the crescent. There is the mass. It's almost like the same one as Mr. Anderson's picture.

Q You used the term included?

A That means it stops. If you're coming down the airway here, you run down the tumor. It comes from in to out, you follow straight here, you kind of run into the mass.

Q We spoke a couple of moments ago about the differential diagnosis you arrived at.

When you arrived at a differential diagnosis, did adenosquamous end up being one of the likely differential diagnoses that you determined?

MR. FINZ: Objection to the form.

THE COURT: I'll allow it.

Q Sir?

A No.

Q Let me ask you this: Have you seen at Johns Hopkins, have you looked at mucoepidermoid tumors on a CAT scan?

A Yes, I have.

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Q Can you tell us approximately how many such tumors have you seen?

A Probably in the range of ten to twelve tumors in the past number of years.

THE COURT: Out of?

THE WITNESS: Out of thousands.

Mucoepidermoid is a relatively uncommon tumor. But like a lot of uncommon things, you kind of know how they appear because when they appear, you know how they appear.

Q Have you seen adenosquamous?

A Yes.

Q Are they also uncommon?

A Yes, they are. Probably range less than three percent.

THE COURT: I'm sorry?

THE WITNESS: Less than three percent.

There may seem as more uncommon adenosquamous.

THE WITNESS: Yes.

THE COURT: Significant?

THE WITNESS: Yes.

THE COURT: Go ahead.

Q Did the appearance of the tumor that Mr. Anderson had removed that had you walked us through on the CT scan, did that appear like any of the adenoid squamous that you've seen?

MR. FINZ: Excuse me. I will object to

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that. It's leading.

THE COURT: Sustained. Why don't you ask him?

Q Doctor, I think you mentioned --

THE COURT: In your medical opinion --

Q In your practice at Johns Hopkins, you've also seen adenoid squamous tumors?

A Yes, I have.

Q Can you tell us, sir, within a reasonable degree of medical certainty whether the tumor that Mr. Anderson had removed that you reviewed for us on the CT scan appeared like any of the adenoid squamous tumors you've seen?

A It did not.

Q Can you tell us, sir, mucoepidermal, that type of

lung cancer, is that type of lung cancer that's crucial so people can survive?

MR. FINZ: I will object to that question. Leading.

THE COURT: Sustained as to form. Ask that a bit differently.

Q Well, you've told us that --

THE COURT: Are you familiar with any studies showing the longevity of those patients that you found authoritative?

A Yes. For example, this one article we looked at

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which described 12 patients.

Q You're referring to the article in Radiology. All of those patients are alive and well. So -- and other articles basically say the same thing, that it's a high survival?

THE COURT: That you find authoritative?

THE WITNESS: Yes, I do.

Q Can you tell us, Doctor, was one of the records that we asked you to review in this case the pathology report that was generated after Mr. Anderson's cancer, cancer operation, lung operation?

A Yes, it was.

Q Can we bring up for the Court and counsel X 2659?

THE COURT: Is that also -- that has been a plaintiff's number.

MR. GORDON: Yes. I believe the plaintiffs marked in all the Interfaith records collectively as 468 A. Is that correct. It's also identified as defendant's A --

THE COURT: Let's refer to it by its designation in evidence already.

Q Dr. Fishman, is this the surgical pathology report that I was just referring to?

A Yes, it is.

MR. GORDON: Judge, can we bring this up?

THE COURT: Yup. It's in evidence.

MR. GORDON: Thank you.

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Q I want you to read one particular statement in this pathology report and maybe my colleague back here can highlight it for us. Whoops. That's no good. Can you read for us the statement that was just yellow highlighted?

THE COURT: It's not on your machine?

A It's on my machine. It is not communicating with any bronchus and shows focal areas of necrosis and hemorrhage.

Q Are you familiar with the term "gross pathologic

examination"?

A Yes.

Q And what does that term mean?

A Gross pathologic examination means when a pathologist has a specimen that's given to him by the surgeon, he visually inspects it, looks at it.

Q Does the language you read for us reflect a gross pathologic examination?

A Yes.

Q And based on your review of the CT scans of Mr. Anderson, was that statement correct?

A The statement is incorrect.

Q What was that?

A The statement is incorrect.

Q Why is that?

A Because it's very obvious to everybody on the

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jury --

MR. FINZ: Excuse me, Judge. I will object to that and ask it be stricken.

THE COURT: Sustained.

A It's very obvious to me --

MR. FINZ: I will object to that.

THE COURT: I'll allow that.

A It's my opinion that the tumor -- it's a tough

crowd.

But it's my opinion that it's very obvious you could see the airway going right into the tumor. The reason the pathologists did two things.

MR. FINZ: I will object to that as going, your Honor, far beyond the question.

Q Well, can you tell us?

THE COURT: Yes. The last portion of the sentence is sustained.

We're in a technical area, Doctor. Let's just take it slow in responding to a particular question.

THE WITNESS: Yes, sir.

Q Let me ask you this: Are there features such as whether a tumor is communicating or encasing a bronchus that you can see on the CT scan that a pathologist may not be able to see --

THE COURT: Counsel, you're leading.

Q Is it your opinion within a reasonable degree of

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medical certainty after you reviewed Mr. Anderson's CT scan with Dr. Fishman that that statement by the surgical pathologist that is the statement it is not communicating with any bronchus was incorrect?

A Yes, that's true.

Q Have you had an occasion?

THE COURT: May I ask you? It's your opinion that that does not correlate with what you see on the CT scan? Am I saying it more kindly?

A You're saying it more kindly.

MR. GORDON: Thanks. You can bring it down.

Q Dr. Fishman, have you in the course of your practice reviewed any of the medical literature on mucoepidermoid lung tumor?

A Yes, I have.

Q And have you seen any among that literature, that medical literature, have you seen any literature that says mucoepidermoid is associated with smoking?

MR. FINZ: I will object unless we identify the literature.

THE COURT: I will allow it. Wait a minute. Counsel, you better approach.

(Whereupon Mr. Gordon and Mr. Finz approach the counsel table.)

Q Doctor Fishman, can you tell us whether in the medical literature you've reviewed you've come across any

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literature that you consider authoritative on the subject of mucoepidermoid in smoking?

A In the literature I reviewed, a number of the

articles did make comment to that.

Q And can you tell us whether any of that literature made any connection between smoking and mucoepidermoid?

MR. FINZ: Objection, your Honor, unless we identify what that literature is so we can confront it.

THE COURT: I'll let you cross-examine.

Q Doctor --

THE COURT: Go ahead.

A In essentially all of the articles I read and from the most recent textbook I read which is Doctor McCloud's textbook or Thoracic Radiologist, it in fact says specifically that mucoepidermoid is not associated with smoking.

THE COURT: Are you now -- let me -- these articles that you consider authoritative are radiology as opposed to pulmonary or oncology or -- I'm trying to define this.

THE WITNESS: The last quote was one of the radiology articles. But in looking at the articles -- I reviewed a lot of them. Some of them were pathology based. Some more focused on pathology. Some more focused on surgery.

That statement was pretty much true -- some

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articles mentioned that a number of patients may have smoked.

But when you read the articles, you can see that there is no conclusion. I'm not an epidemiologist. But I'm saying what I read.

MR. FINZ: I will ask it be stricken. It's been total hearsay. I will object to that.

THE COURT: Overruled. Overruled.

Q Dr. Fishman, I think you mentioned, if I recall it right, the most latest CT scan of Mr. Anderson you reviewed was February of 2000; is that correct?

A Yes.

Q Can you tell us within a reasonable degree of medical certainty based upon your review of that film whether there is any indication that Mr. Anderson's cancer has recurred?

A There is no evidence of any disease.

Q In the course of your practice at Johns Hopkins, Dr. Fishman, have you had an occasion to review CT scans or x-rays for emphysema?

A Routinely.

Q And can you give us an approximation -- we did this before -- with lung cancer, can you give us an approximation how many CT scans you reviewed in connection

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with an emphysema diagnosis?

THE COURT: Can we start this after lunch?

MR. GORDON: I have less than two minutes.

THE COURT: Okay. Your way.

Q Can you give us an approximation in the past say 12 months how many CT scans you reviewed in connection with an emphysema case?

A Well, probably thousands of patients. Because in part what we do is in -- we do a lot of what's called high resolution CT where you're looking for lung disease in the lung parenchyma.

One of the possibilities is emphysema. We do that five to ten times a day. So it's a very common thing for us to do.

Q What features, if any, on a CT scan suggest to you that there might be emphysema?

A Well, when you're looking at the lung tissue or lung parenchyma you see holes in the lung parenchyma, there is destruction of the tissues of the lung. That's the classic thing.

Your aerospace is increasing in size because of lung destruction. That's what you look for. You don't see the normal pattern of the lung tissue. You see holes kind of like Swiss cheese if you're taking sizes.

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Q Any other features one would see?

A You could see hyperinflation. The bronchi could be dilated. Typically, what you're looking at is the lung tissue. That's very nice to see on CT.

Q Can you tell us, sir, again, within a reasonable degree of medical certainty based upon your review of Mr. Anderson's CT scans whether you found any indication that he had emphysema?

A He did not. No evidence of emphysema on the scans.

Q As you recall it on any of the written radiology reports pertaining to Mr. Anderson's CT scans or x-ray, any indication of emphysema?

A They do not.

MR. GORDON: I have no further questions, Judge.

THE COURT: Fine. I'll see you at 2:05. Have a nice lunch.

(Whereupon the jury leaves the courtroom.)

(A luncheon recess was taken.)

(Whereupon Esther G. Spielman was relieved by Mark Bowin as official court reporter.)

(Case continues on next page.)

AFTERNOON SESSION

(Dr. Fishman resumes the stand.)

THE COURT: Let me ask the doctor a question.

Did you notice the appropriate identification of the plaintiff on that main address, etcetera?

THE WITNESS: That it was his film?

THE COURT: Yes.

THE WITNESS: Yes.

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THE COURT: So indicated. If it's not in evidence, it now is. All of them; the the whole pack.

MR. SHEFFLER: Thank you.

THE CLERK: I'll add this to 468B.

THE COURT: Yes.

COURT OFFICER: Ready, Judge?

THE COURT: Yes.

(Jury enters the courtroom.)

THE COURT: Go ahead. We're up to you, Counsel.

MR. FINZ: Good afternoon, everybody.

CROSS-EXAMINATION

BY MR. FINZ:

Q Good afternoon, Doctor.

A Good afternoon.

Q Doctor, I'm going to be asking you a series of questions, and I hope that you'll try to be as responsive to my questions as you possibly can. Would you do that please, sir?

A Absolutely.

Q I appreciate that.

Now, you and I have never met before, other than seeing each other in court this morning; correct, sir?

A Correct.

Q All right. Now, you are not a board certified pathologist, are you?

A No, I'm not.

Q And there is such a thing called pathology; that is, doctors actually specialize in pathological science or pathological research; is that correct?

A Yes.

Q And they go to medical school, as you have done, right?

A Absolutely.

Q And they decide that instead of becoming radiologists, as you wanted to become, they decide

they want to look into microscopes and examine cell structures and examine DNA, and the nuclei of the cell, correct? That would be the pathologist's role; is that correct?

A Yes.

Q And that's not any of your specialties; am I right about that?

A Right.

Q Now, you're not a pulmonologist, are you, sir?

A No.

Q A pulmonologist is one who actually treats people with lung disease, correct?

A Correct.

Q And you are someplace in the pecking order of doctors who help pulmonologists along the way to make a diagnosis; isn't that correct?

MR. GORDON: Just to form, Judge.

MR. FINZ: Let me remove the word "pecking order." I'm sorry. I didn't

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mean to put anything you did down. Please understand that.

THE COURT: How about "diagnostic assistance"?

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MR. FINZ: That's a better word, Judge.

Q You are there to offer diagnostic assistance to a treating doctor, such as a pulmonologist; would that be correct, Doctor?

A I'm there to work with the pulmonologist to help the patient get the best care possible.

Q You're not the one who sits at the bedside of the patient and actually takes the history of the patient, are you?

A No.

Q You're not the one who says -- You're coming in with chest pain or you're coming in with a pain on the right side of your body or next to your lung or whatever the case might be, you're not the one to take that kind of information down, are you?

A No, I'm not.

Q You're not the one to make -- actually hold a physical examination or conduct a physical examination of a patient; is that correct?

A Typically not.

Q By that I mean, you don't palpate a patient; you don't feel to see if there are any

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bumps or nodules or any things that could be described or felt as palpable lumps; is that right?

A Correct.

Q You don't do any of that. You don't ask a patient, for example, to: "Raise your arms and let me feel around your chest?" You don't do any physical examinations of the patient. Am I right about that?

A I do sometimes; not usually.

Q But that is not your role.

A No.

Q All right. So, therefore, you're not the one who actually keeps a record of a patient with respect to what a diagnosis would be of a particular patient; isn't that right?

A No, that's incorrect because --

Q Let me reframe the question. Let me reframe the question. A patient normally does not go directly to you; isn't that right?

A Typically, they don't refer themselves. Is what you mean?

Q Exactly. They'll go to a doctor and say "Doctor, I don't feel well. I've been coughing. I'm short of breath." And the doctor would

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generally take a history of such a patient; isn't that right?

A Correct.

Q And part of the history would probably be "Well, how long have you had the shortness of

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breath?"
Wouldn't that be a legitimate question?
A Absolutely.
Q And, "How long have you been coughing?" Would that be a legitimate question?
A Yes.
Q And wouldn't a legitimate question also be, "Do you smoke cigarettes"?
A Yes.
Q That would be a very important question; isn't that right? And a doctor would normally make that kind of a record; isn't that correct?
A Correct.
Q And then based upon the history, the doctor would then conduct a physical examination and then make findings; is that correct?
A Yes.
Q And then, possibly, hopefully, make some kind of a diagnosis; isn't that right?

A Possibly.
Q Possibly. Sometimes the doctors can't always do that; isn't that right?
A Correct.
Q Because sometimes, if a patient comes in and says, "I've got a pain in my chest," and the doctor then conducts or gives an electrocardiogram and finds that everything is normal, the doctor may be looking at someplace other than the heart; isn't that right?
A Correct.
Q The doctor will say, "Wait a minute. Perhaps I should take a chest x-ray." That would be something that a doctor would be doing under that type of complaint --
MR. GORDON: Objection to form.
THE COURT: Counsel, start that over again.
MR. FINZ: Yes.
Q If a patient complained of a chest difficulty, such as shortness of breath, coughing, would it be within standard practice, medical practice, for a doctor to take or to order a chest x-ray?

Would that be --
A Yes.
Q And, in fact, if the doctor didn't do that and if something happened to this patient by way of something that could have been discovered on the x-ray, that could serve as a basis of a medical malpractice situation; isn't that right?
THE COURT: Sustained.
It would not be proper.
MR. FINZ: Okay.
Q It would not be proper; is that correct?
A You would probably know better than me what's malpractice.
THE COURT: No, no. I said, "Sustained." Don't answer it.
Q Okay. So that the doctor is now

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examining this patient, now seeks the help of a radiologist, if he doesn't have the equipment in his opens office or her own office; isn't that right?

A Typically, they'll send them to a radiologist.

Q Fine. But if the doctor, for example, happens to be an internist and the doctor does have

x-ray facilities for a chest x-ray within the office itself, then the likelihood is that that could be done in the doctor's office; isn't that right?

A Sure.

Q And then the doctor -- be he or she, an internist, one of internal medicine -- could look at that x-ray -- and they're generally trained to read a chest x-ray; isn't that correct?

A Incorrect.

THE COURT: Counsel, one question at a time.

Q They're not trained?

A They're not trained to read x-rays.

Q Excuse me. In other words, when we go to a doctor and the doctor takes a x-ray of our chest and tells us: "Everything is okay; don't worry. I see everything is clear," we shouldn't rely upon the doctor because he's not trained in reading a x-ray of a chest; is that that what you're telling us?

MR. GORDON: Objection.

THE COURT: Sustained.

Q You don't have to answer it.

A I'll be happy to answer it.

THE COURT: Sustained. No, no, no, no. It's not up to you, Doctor.

THE WITNESS: Okay. Thank you. Okay.

THE COURT: It's up to me.

THE WITNESS: Sorry.

THE COURT: I leave you to medicine. Leave me to law.

Q Now, Doctor, so that we understand exactly what a x-ray is, you made an explanation before; but am I correct that, in essence, we're dealing with a tube that actually sends out a ray; is that correct?

A Correct.

Q And then the person or the hand -- you described as "the hand" would be there (indicating.)

A Right.

Q And then there would be a film behind the person or behind the hand (indicating.)

A Right.

Q Or if we were lying down, the film would be under us; is that correct?

A Correct.

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Q The whole object is that -- you said that air is black, right?
A No. In CT scans --
Q It would show black, right?
A Right.
Q That's because the ray is going right through, and there's nothing blocking that ray; isn't that correct?
A Correct.
Q And what we get on the other side is an image that is black; isn't that right?
A Well, it's varying levels of grey. I wouldn't call it black.
Q Varying levels. You start off with plus a thousand or minus a thousand?
A That's a CT scan, not plain x-rays. There's a substantial difference.
Q Let's just talk generally so we have a general understanding as to what the x-ray actually does accomplish and doesn't accomplish, and then we'll go to CT scans. Right now, I'd like to talk about x-rays.
So, essentially, what the x-ray is doing

is sending out a ray; and if there's something solid that that ray hits, then that in some way is imaged on that film; isn't that correct?
A True.
Q And to the trained eye, we can actually look at that film and then by looking at shadows, we can make identifications as to what the medical significance of that shadow may or may not be; right?
A Correct.
Q And we do that by looking at certain landmarks within the anatomical structure of the human body; isn't that right?
A Correct.
Q In other words, we don't go into the dark. We know that the spine is in a certain place, correct?
A Correct.
Q We know that there are organs and structures within the body which gives us a road map; isn't that correct?
A Correct.
Q And that is what you described earlier as a road map, right?

A Partly.
Q Partly. Essentially, the x-ray is giving us a two-dimensional image, right?
A Correct.
Q And that is why we will take more than one shot. For example, we'll take an AP view --
What's an AP view, by the way?
A That's a view straight at the patient.
Q We'll take a PA view. What's a PA view?
A Depends how the patient's positioned.
Q Sometimes we'll take a lateral view; a side view, right?

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A Correct.
Q And then you radiologists would take the various different views and put them on your shadow box and then try to recreate, if you can, a three-dimensional picture in your own mind based upon your own training, correct?
A Correct.
Q And then you'll make some kind of a finding, right?
A Uh-huh.
Q Now, can you see cancer on a x-ray? Yes or no?

A I could see findings suggestive of cancer.
Q Sir, question: Can you see cancer on a x-ray?
A Yes.
Q Now, are you telling us that you can identify a certain picture that will give you an indication that what you're looking at could be a cancerous growth? Is that what you're saying?
A Yes.
Q Okay. But see to see cancer itself, to see cancer, you have to look at the cells; isn't that right?
A To see the specific cell type, yes. In cells, yes.
Q And you don't see cells when you look at a x-ray film; isn't that right?
A Correct.
Q Now, you don't do bronchoscopies as a general practice, do you?
A No.
Q That's not part of your role as a radiologist; is that correct, sir?
A Not doing the bronchoscopies.

Q Not doing -- I thought that was my question.
A No.
Q Thank you. So that we understand what a bronchoscopy is, let's just review that together.
Well, let me show you something here. First of all, sir, would you say that this is a reasonable -- fair and reasonable drawing --
THE COURT: Not to scale.
MR. FINZ: Without scale, of course, your Honor. Thank you.
Q -- of the bronchus and the trees, etcetera?
A I would say it's a very rough guesstimate.
Q Very rough guesstimate. As rough as yours was, would you say?
A No, it's worse than mine, I'd say.
Q Well, I didn't go to medical school for as many years as you did. But would you say that is a rough drawing of what we're talking about?
A Roughly.
Q So that we can understand what the

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bronchoscope is, I think you used a pointer so let

me do that.

Am I correct, sir, that you said before that -- by the way, the one who performs the bronchoscopy is not a radiologist; am I correct?

A Correct.

Q That's not the job of the radiologist.

A No, it's not. We help guide them, but we don't do them.

MR. FINZ: I understand.

Could we possibly get this light off? Would that be okay? Thank you very much. I appreciate that.

Q (Cont'g) The one who performed the bronchoscopy is not a radiologist, such as yourself, right?

A Right.

Q And that's a very highly-schooled bit of training, just as your area is highly schooled; isn't that correct?

A Correct, yes.

Q One goes to medical school and one takes very special training in using what is known as an endoscope or a bronchoscope; isn't that right?

A Correct.

Q And it's considered a procedure that is an invasive procedure; isn't that right?

A Correct.

Q It's an invasive procedure because, in essence, you are introducing something foreign into the body itself; isn't that right?

A Right.

Q You're introducing an instrument, right; a scope?

A Yes.

Q Correct?

A Uh-huh.

Q Now, in order to do that, the person has to be put under anesthesia to a certain degree; isn't that right?

A Yes.

Q And there's got to be people around and a person has to be monitored rather carefully as, indeed, such a person should be; correct?

A Correct.

Q And the one who is proceeding with this procedure is one who has training in the use of a bronchoscope; isn't that right?

A I hope so, yes.

Q We hope so, obviously.

We assume that such a person also has had residence training and has board examinations and is board certified, particularly one who's with a hospital; isn't that right?

A Uh-huh. Yes.

Q We would expect that; isn't that right?

A Yes.

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Q And we as patients would expect that such a person be so qualified?
A Correct.
Q And Clyde would have a right to expect that the person who performed the bronchoscopy on him would be so qualified; isn't that right?
MR. GORDON: Objection. Form.
THE COURT: Sustained.
Q So now this trained person introduces this scope down the trachea, correct?
A Uh-huh.
Q And then comes to the carina, which you say is the breakoff point of the right and the left, correct?
A Correct.
Q Now, you did not -- of course -- let me

withdraw it. You were not present when the bronchoscope was performed; isn't that correct?
A Correct.
Q You don't know who was in the room; isn't that right?
A True.
Q You don't know -- by the way, who was the one who performed the bronchoscopy. Do you know the person's name?
A I don't remember off hand.
Q Do you know anything about the qualifications of this person?
A No.
Q Do you know anything about the person who was administering any kind of anesthesia?
A Do not.
Q Do you know the name of the person?
A No.
Q Do you know the name of the nurse who was there?
A No.
Q Do you know how long this lasted? What time it started? What time it finished? Anything of that kind?

A No.
Q Okay. Now, Doctor, you have received a number of grants; have you not?
A Yes.
Q In some work, right?
A Uh-huh.
Q Now, have any of those grants that you've ever received dealt with M.E.T.?
MR. GORDON: Objection.
A You want to know what the abbreviation stands for?
Q You don't know what it means?
A I do. The jury might not.
Q Let me take care of that. Thank you.
Have you ever dealt with any grants or handled any grants that dealt with M.E.T.?
A No.
Q Now, "M.E.T;" that's what we just spoke about, right?

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A Uh-huh.
Q Now, Doctor, M.E.T. is the acronym -- actually, the first letters of muco -- the "M" -- epidermoid -- the "E" -- tumor, the "T"; is that correct?

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A Yes.
Q That's the way we get the word -- that's the way we get M.E.T., mucoepidermoid tumor, right?
A Absolutely.
Q Now, you've had approximately thirty grants or so in your professional career; am I correct, Doctor?
A I haven't had thirty grants.
Q I counted them last night. You have about thirty.
A Okay.
Q Will you accept that?
A All right. Fine.
Q Some of these grants are from companies like Sun Microsystems -- corporate grants?
A Right.
Q Whatever they might be, okay; am I correct about that?
A Yes, sir.
Q So just to backtrack if I can, none of these grants -- these are research grants; isn't that right?
A Correct.
Q So am I correct in saying, Doctor, that

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you have never done any research with respect to these grants on mucoepidermoid tumors, right?
A Correct.
Q Okay. Now, Doctor, have you ever published an article on -- now I'm going to say -- instead of saying "mucoepidermoid tumor," which is quite a mouthful, I hope you won't mind if I just say MET. I think everybody will know what I'm saying when I say MET.
Have you ever written any articles that were published in peer-reviewed journals on MET?
A Not specifically, no.
Q Now, Doctor, you have written -- I think you said earlier, if my hearing was correct -- that you have published approximately 700 articles; is that correct?
A Correct.
Q And of the 700, couldn't you find room a little --
THE COURT: Counsel.
MR. FINZ: Forgive me, Judge.
Q Of the 700, Doctor, am I correct that not one dealt with MET, right?
A Correct.

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Q Now, I think you've also written some book chapters, right?
A Correct.
Q Now, of all the book chapters you

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wrote -- and there were about eight or ten?
A Eight or ten books. I wrote probably fifty chapters.
Q Let's talk about the books, eight or ten books. Of the eight or ten books that you wrote which dealt with radiology, CAT scanning and nuclear radiology and a lot of very esoteric things; all important things in science, of course?
MR. GORDON: Object to form.
THE COURT: I'll allow it.
Q Did any of those books -- First of all, did any of those books have a title with "MET" in its title?
A No.
Q Did any of those books deal with MET?
A No.
Q Okay. Let's move on to the chapters. How many chapters have you had?
A Probably fifty; in that range.
Q Have any of the chapters that you've had

ever dealt with MET?
A No.
Q Now, you have delivered, you said, hundreds and hundreds of seminars; am I correct?
A Uh-huh.
Q And you said that most are within the United States; you don't like to travel outside the United States. We can understand why.
Did any of those seminars that you have delivered had as its principal subject MET and CAT scanning?
A No. Not MET as a primary subject.
Q All right. Now, you've also delivered lectures -- am I correct?
A Correct.
Q -- through various medical schools and various universities. Have any of those lectures ever dealt with -- principally dealt with MET?
A Actually, I've shown cases of MET in my lectures.
MR. FINZ: That was not my question. I move to strike as not being responsive.
THE COURT: Sustained. Let's go on.
Q I think you said earlier that you

probably have contact in one form or another with approximately 15,000 patients a year, correct?
A At least.
Q At least. Maybe more.
And I think you stated -- if I'm wrong, please correct me, Doctor.
I think you stated that, in all, you have had contact with approximately, more or less, 300,000 patients; is that right?
A In terms of their studies, definitely.
Q Okay.
A CT scans.
Q 300,000, throughout your career, correct?
A Yes.
Q You also stated, in sum or substance,

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that the total number of patients that you have seen with MET, you saw ten to twelve times in your medical career, right?

A Correct.

Q Now, sir, simple mathematics. Would tell us that if we took a percentage of the 300,000 patients that you have had contact with in your career and then we give you the benefit of the 12 times that you've seen MET, it comes to

.00004 percent, or that you have seen MET four times out of 100,000 patients; is that correct?

A You can look at it that way.

Q Thank you.

Now, of those four out of the hundred thousand that you have seen -- first of all, does MET have varying grades attached to it?

A Yes.

Q It has what?

A Two grades. A low grade and a high grade.

Q Now, with respect to the low grade, of those four patients out of a hundred thousand, how many had low-grade MET?

A I don't recall.

Q How many had high-grade MET?

A I don't recall. I think most of them --

Q Well, you answered the question. You don't recall. That's an answer.

THE COURT: He thinks --

A I think there was one or two that I knew had high grade. The rest were low grade. But I didn't have the exact number.

Q With a yes or no: Is there a distinction

between low grade and high-grade MET?

A There's a pathologic distinction.

Q My question, sir -- pathological distinction. In other words, this is a distinction that would would be made by a pathologist, right?

A Typically.

Q Based upon looking into a microscope and looking into a slide and looking at cells; isn't that right?

A Correct.

Q And you don't do that, do you?

A No.

Q And you haven't done that in this case, have you?

A No.

Q And you wouldn't be expected to, as a radiologist, right?

A No.

Q Now, we would have to agree, would we not, sir, that MET is extremely rare; right?

A It's less than 1 percent of lung masses.

Q Extremely rare; isn't that right?

MR. GORDON: Objection. Asked and answered.

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THE COURT: Would you consider one percent rare?
THE WITNESS: Yes. That would be rare.
Q Now, sir, isn't it a fact that it's really --
THE COURT: Let me ask you a question. Of those four people that you had -- I think those are were the ones you had -- how many of those were smokers?
THE WITNESS: How many of those did I diagnose retrospectively -- I don't know the smoking history.
THE COURT: Go ahead.
Q Coming up to the percentage, sir. Have you ever heard of Dr. Eugene Mark?
A No.
Q You've heard of the New England Journal of Medicine; have you not?
A I've heard of them. I review for them.
Q Would you say someone who's been an editor with the New England Journal of Medicine in pathology and reports case studies every time this

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issue comes out --
How often does it come out, by the way?
A Every other week.
Q If he's had this position for about nineteen years from Harvard, would you say from a peer review point of view, he would be somebody highly respected?
MR. GORDON: Objection to form.
THE COURT: Sustained.
You "over-if'd." You had at least four questions that I could discern.
MR. FINZ: I'm saving four minutes, Judge.
THE COURT: No, you're not. That's the problem.
Q Would you say someone who's an editor of New England Journal of Medicine is someone who would be well regarded in this field?
A Sure.
Q If he's been an editor of pathology for nineteen years, that is quite an accomplishment, is it not, in the field of pathology?
MR. GORDON: Objection to form.
A I would just --

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Q Could you answer that with a yes or no?
THE COURT: Sustained.
Q Now, would you consider someone who's been an editor with the New England Journal of Medicine for the past nineteen years as an authority in the field of pathology?
MR. GORDON: Objection. No foundation.
THE COURT: I'll allow it.
Either he does -- a pathologist who's the associate editor of something, what

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we would call a case study?
MR. FINZ: That's right, sir.
THE WITNESS: Could I answer that in more than a yes or no answer?
THE COURT: Absolutely. Otherwise we'll never get past it.
THE WITNESS: Here's a point --
MR. FINZ: May I withdraw the question? Judge, I don't want a response that is not responsive to my question.
MR. KACZYNSKI: And I object to the characterization.
MR. FINZ: I'm not going --

THE COURT: Fine. He withdraws it. Let's go on.
Q Have you ever heard of this article entitled, "Mucoepidermoid Lung Tumors," one of the authors of whom is Eugene J. Mark --
THE COURT: No, no. You see, you do two things at once.
MR. FINZ: Judge, may I step up, please?
THE COURT: Yes, please.
(Diane Dorsey relieves Mark L. Bowin as Official Court Reporter.)
(Continued on the following page.)

CROSS-EXAMINATION
BY MR. FINZ: (Cont'd)
Q Have you ever heard of the article, sir, Mucoepidermoid Lung Tumors?
A Let me see the article.
Q Of course. Certainly.
A A lot of articles have almost the same titles. I have -- in fact, I know the first author very well.
Q Okay, would you consider that to be an authoritative work, sir?
A It was authoritative work in 1988; yes. It was published.
Q Would you consider that to be an authoritative work, sir?
A Yes.
Q Okay, thank you, sir.
Would you agree that mucoepidermoid lung tumors are uncommon, representing 0.2 percent of all lung tumors?
MR. GORDON: Objection. Asked and answered.

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THE COURT: Overruled.
Q Would you agree with that, sir?

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A It's in that approximate range.
Q 0.2 percent. Thank you.
A In that article.
Q Thank you.
Now, are you familiar, sir, with the Armed Forces Institute of Pathology?
A I teach there. Yes.
Q So you're familiar with it.
A Yes.
Q Do you know that the Armed Forces -- do you know if --
THE COURT: Do you find it authoritative.
Q Do you find the -- a publication of the Armed Forces Institute of Pathology authoritative?
A I would have to see the article.
Q Okay, I can show it to you.
THE COURT: Mr. London, can I see the previous article referred to, just for a moment?
A It's in a very reputable journal. It's in Cancer; and again, it's a 1987 article. This seems authoritative.
Q Will you say it's authoritative, sir?

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MR. GORDON: Do we have a copy for us?
THE COURT: He said it is. Go on.
MR. FINZ: Yes. Your Honor, may we step up a moment please?
(Off-the-record bench conference.)
MR. GORDON: Thank you.
MR. FINZ: Excuse me, your Honor. I would want to question the good doctor about that article, but I only have one copy.
THE COURT: So why don't you do that? Oh, they have it.
MR. FINZ: They have it, Judge.
THE COURT: So can we have it back?
MR. FINZ: Thank you very much.
Q Now, sir, with respect to this article, am I correct, sir, that that article actually breaks down M-E-T or MET into low grade and high grade, and if you look at the first page you'll see low grade mucoepidermoid tumors? You see that, sir?
A Yes.
Q And then if you look at the several

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pages beyond that you'll see that it deals with --
THE COURT: Counsel.
(Jury exits courtroom.)
I would like to see a few of you up here.
(Off-the-record bench conference.)
COURT OFFICER: Jury entering.

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COURT CLERK: You may be seated.
CROSS-EXAMINATION
BY MR. FINZ: (Cont'd)
Q Before we get back into that article, doctor, if I may just swing back, wind back just a little bit to the bronchoscope. Actually the bronchoscope is something that the doctor is actually using to visualize the lung tissue itself; isn't that right?
In other words, the scope; there's a camera he can actually look through it and actually see what he's looking at, the lung tissue itself?
A You're looking at the airways.
Q But he can visualize it. He can get direct contact with the field, with what is actually there to be seen?

A His eye contacts wherever he is.
Q Wherever he is exactly; and following that eye contact where he is, he also has the capability, does he not -- let me withdraw that question.
He also has the capability of actually taking tissue samples; isn't that right?
A Correct.
Q And is that typically acceptable to take a tissue sample whenever using a bronchoscope?
A That's typically why you would do the bronchoscopy.
Q So that you could then send to the laboratory, send to pathology; is that correct?
A Yes.
Q And have pathology put under the microscope and see what kind of tissue it is. Is it benign tissue? Is it cancer tissue?
A That's correct.
Q There's a big difference between a benign cell or a normal cell and a cancer cell; isn't that right?
A Correct.
Q The normal cell has a nucleus; correct?

A Go ahead.
Q It has a membrane; correct? It has cytoplasm around it; correct?
A Go ahead. Yes.
Q Yes; okay. Whereas you take a cancer cell, a cancer cell would be a cell perhaps that would -- cancer perhaps would start with a single mutated cell in the body; isn't that right?
A Yes.
Q This single mutated cell would be a cell that perhaps the nucleus itself is deformed. The DNA within the nucleus is deformed; is that correct?
A Correct.
Q And unlike the regular cell, has some systematic purpose or anatomical purpose within the body itself. The cancer cell really has no purpose other than just to proliferate; correct?

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A Correct.
Q And can we say in the most simplistic sense, a normal cell has a blueprint of growth and blueprint of function?
A Yes.
Q The cancer cell has no blueprint; isn't

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that correct?
A Right.
Q It just proliferates and grows, and it takes and eats up everything in sight; correct?
A It has an abnormal blueprint; right.
Q An abnormal blueprint?
A Correct.
Q And it needs its own nutrients; isn't that correct, to survive?
A Correct.
Q And part of the nutrients that it uses for its own survival are actually normal cells within the body itself; correct?
A Correct.
Q And as those cell are being used to feed the cancer cell, that normal cell will die; isn't that right?
A Correct.
Q And the nutrients that the cancer cell will use will be the oxygen of the normal cell; correct?
A Yes.
Q The nutrients are the proteins of the normal cell; correct? The food is the normal

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cell; is that right?
A Okay.
Q An the normal cell will ultimately give in, be destroyed; correct?

MR. GORDON: Okay, Judge. I think we're getting beyond the scope of the direct at this point and a bit repetitive.

THE COURT: I will allow it. Let's move the process along.

Q All right. So now, sir, if we can come back do this article, this article deals with a collection by the Armed Forces Institute of Pathology.

First of all, identify that organization. Is that an organization that operates out of Washington DC?
A It's near Washington DC; right.
Q And is it an organization that is part of the United States Government?
A Part is, part isn't. It's separate.
Q All right, is it a prestigious and authoritative organization? I think you said that before.

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A Yes.
Q And does it have pathologists of some national repute within its own board itself?

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A It would seem so.
Q And they do research, do they not, with respect to cancer?
A I think so.
Q Okay. Now, sir, you've now had an opportunity to read this article which is entitled Mucoepidermoid Tumors of the Lung; correct, sir?
A Correct.
Q And this is authored by Samuel A. Yousem and Liselotte Hochholzer, both of whom are MDs; is that correct, sir?
A Correct.
Q And this is a collection of cases that were collected over a 26-year period of time; isn't that right from 1960 to 1986; correct?
A Correct.
Q And the total collection that the Armed Forces Institute of Pathology and these researches collected were a total of 58 cases in 26 years; right?
A Correct.

Q Now, sir. In 26 years from 1960 to 1986, isn't it true that there were approximately or in excess of 2,000,000 deaths in the United States during that 26-year period from lung cancer?
A I don't know the number.
Q You're not familiar with that statistic?
A No.
Q Of this study, sir, this study deals with high grade and low grade mucoepidermoid tumors; is that correct, sir?
A Correct.
Q Now, does it also indicate the number of the 58 that were found to be in the low grade and the number that were found to be in the high grade?
A Yes, it does.
Q Does it also deal with what is known as epidemiology? By that, I mean, does it deal with age groups?
THE COURT: The doctor knows what epidemiology is.
MR. FINZ: Well, I just want to make sure.

THE COURT: This jury has heard enough about epidemiology to last a lifetime.
A Could I just explain a little bit about the article?
Q No.
A But, you see, it's the AFIP --
Q Thank you. I'll ask my question my way if you don't mind.
MR. GORDON: Move to strike, and I think the witness was --
THE COURT: You'll have a chance to ask him about it. Let's move along.
Q Now, of the 58 cases that were

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collected, sir -- before we get into that, can you tell high grade from low grade by using a CAT scan?

A If you?

Q By using a CAT scan, can you tell high grade from low grade by using a CAT scan?

A Potentially you can.

Q You say you can?

A Potentially.

Q Sir, is there one article that you can

point to in the world literature that says you can differentiate between low grade and high grade mucoepidermoid tumors by the use of CAT scan? Is there any article in the world literature that you can cite to us? "Yes" or "No"?

A Not specifically.

Q Okay, thank you.

THE COURT: Well, we have another article for you to write.

THE WITNESS: Yes.

Q You've answered my question. The answer is "No". Thank you.

Sir, would you agree that in this study of over a 26-year period in which 58 patients were found to have mucoepidermoid tumors, that within that study, sir, that the median age; the median age of that entire group was 29; is that correct?

A Okay, it was a range of nine to 78, but the median average was 35. The median was 29.

Q That's exactly what I said, the median was 29.

Now, do you know how old Clyde Anderson was?

THE COURT: Wait. Now, I'm going to

stop you.

Would the jury like to know the difference between the median and the average?

MR. FINZ: I will ask that.

THE COURT: Ask the question.

Q Doctor, in the average age if you're dealing with ten subjects, you would add up the ten and then divide by ten; isn't that correct?

A Right.

Q That would give you an average age.

Now, there's a difference between an average age and a median age; isn't that right?

A Right.

Q And one of the reasons that it is done in the medical research area is to not give a distorted figure. For example, you may have -- if you have ten people, you may have nine who are age one, and you may have one who is age 80.

MR. GORDON: Objection to form.

Q And if you took the average median age it would be 42 which would not be correct; isn't that correct?

MR. GORDON: Objection to form.

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THE COURT: Sustained. The median, however, is when you have 52, you're looking for the 26th or 27th person, and the age of that person would give you the median age.

Have I explained it correctly?

THE WITNESS: Absolutely.

THE COURT: Okay, there is a difference.

Q Okay, so the median age is 29; is that right?

A In this series.

Q Well, in that series. That series covers a period of 26 years; isn't that correct, from 1960 to 1986.

THE COURT: Counsel.

MR. FINZ: May I step up?

THE COURT: Counsel, he's agreeing. Let's move along.

MR. FINZ: I'd like to.

THE COURT: Okay, in that series, that's the median.

Q Is there another series that was put out by the United States Armed Forces Institute of

Pathology -- "Yes" or "No" -- after this one on mucoepidermoid tumors?

"Yes" or "No", sir? Do you know that?

A Not to my knowledge.

Q Okay, thank you. Now, sir. Coming back to this article, are you aware that in the low grade grouping which you say -- Mr. Clyde Anderson has the low grade mucoepidermoid tumor. Are you aware of that, sir?

MR. GORDON: Objection.

THE COURT: Now, approach.

(Off-the-record bench conference.)

You didn't attribute the level of MET. You didn't give Mr. Anderson a high or low type?

THE WITNESS: No.

THE COURT: Okay, next.

Q Now, do you know whether or not he -- according to you, would he fall into the low grade or the high grade?

A Well, I think what you could look at is the outcome.

Q Sir. Do you know whether or not -- can you tell us whether or not Mr. Anderson fell into

the low grade or the high grade? Can you do that?

A Not from the scan specifically.

Q You don't know?

A I don't know.

Q Are you aware, sir, that in the low grade, only one Black person has ever been identified as having MET during that period of time from 1920 -- 1960 to 19 --

THE COURT: In that study?

MR. FINZ: In that study.

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MR. GORDON: Objection.
THE COURT: I will allow that.
Q Are you aware of that, sir?
A No. I can read it, but I am not aware of it.
Q Shall I read that portion to you?
A I'll take your word for it.
Q A radiologist is one step toward -- for the most part, one step toward a final diagnosis; is that correct?
A We try.
Q Okay; and sir, the next step toward that or the final step toward that diagnosis would be the pathologist; isn't that right?

A The final step.
Q Okay, now, with respect to the pathologist, sir, as a general rule, doctors would usually defer to the pathologist who was actually looking at the actual cellular structure of the pathology itself; isn't that right?
A As a general rule.
Q And certainly if a pathologist is a highly qualified pathologist, then one would more likely be inclined to defer to such a person; isn't that right?
A It would depend on -- can I answer the question?
It would depend on what the findings -- the pathologist says and what he saw in the X-ray, because it would not be uncommon even of the best pathologists to say something.
Q Okay. You've answered my question. Thank you.
Sir, in the high grade -- did I say something funny? You seem to be smiling.
THE COURT: Counsel, next question.
Q In the high grade, could you tell us, please, how many smokers were there in the high

grade in that study?
A I don't know. I haven't read the articles.
Q You don't know the numbers?
A I don't know what they are. I could read it.
Q Could you tell us without reading the article as to how many smokers have been found to be in the high grade series of MET? Do you know that?
A In this article?
Q Anyplace?
A I know that.
Q Can you answer the question?
THE COURT: Wait. Wait. Hold it.
You said, "anyplace"?
THE WITNESS: Anyplace.
Q What is the percentage?
MR. KACZINSKI: Your Honor, he's not allowing him to answer the question.
MR. FINZ: Let me reframe it.

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THE COURT: I'm really trying to get an answer.
A In the articles that I have read, the

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most recent articles -- again, what was written in 1987 and was written in 2000 is different.
Q Excuse me. I'm not asking --
MR. KACZINSKI: Your Honor --
MR. FINZ: Your Honor, it's not responsive to my question.
THE COURT: Withdraw the question. Start again.
MR. FINZ: I will withdraw the question; okay.
Q Isn't it a fact, sir, that even in MET, 80 percent of MET with high grade, 80 percent are smokers? Isn't that right, or don't you know?
A I never heard that number.
Q You don't know; is that correct? Okay. Now, did you ever look at the report of the surgery that Mr. Anderson had in this case?
A I think so. I have.
Q Did you? And did you find anything in that report that would indicate MET, mucoepidermoid tumor by the surgeon? Did you find anything in that report?
A The surgeon ostensibly doesn't --
Q Did you find anything in that report?

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That's a "Yes" or "No" question.
MR. KACZINSKI: Your Honor, he is not allowing him to answer the question.
A May I see the report? I'd be happy to answer the question.
Q Of course.
A The -- basically the surgeon doesn't say much of anything here.
Q I see. So now you disagree with what the surgeon did; is that correct?
MR. GORDON: Objection, your Honor.
MR. KACZINSKI: Objection.
THE COURT: Sustained.
Q Let me ask you this. The surgeon is the one who is actually opening the chest; is that right?
A Correct.
Q And the surgeon is actually looking at Mr. Anderson's lung; isn't that right?
A Correct.
Q And the surgeon is the one who is actually seeing not a shadow as you do on a CAT scan or on an X-ray, but he's looking at the actual mass itself; isn't that right?

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MR. GORDON: Objection. Mischaracterizing his testimony on the CAT scan.
THE COURT: The surgeon is eyeballing it.
Q He's eyeballing it; right?

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A At best; right.
Q He's right there; correct?
A He's taking it out; right.
Q And now he's taking it out; isn't that right?
A Right.
Q Now, sir. I'm going to read this together. It describes the operation; is that correct sir?
A Correct.
Q Okay, and I'm going to read three lines down to the second paragraph.
"The mass was palpating".
Now, by the mass, the surgeon is now talking about that cancerous ball, or that cancerous structure; isn't that correct?
A He's talking about the mass he felt.
Q Which is about five centimeters; right?

A Correct.
Q About two and a half inches in circumference; is that correct?
A Approximately; correct.
Q A little smaller than a baseball. Perhaps a little larger than a golf ball; is that correct?
A About two inches. Go ahead.
Q Now, it says: "The mass was palpated in the middle of the right upper lobe".
Do you see that, sir?
A Okay.
Q So he said that he felt that mass in the in the right upper lobe; isn't that correct?
A Yes.
Q Is there one single word about the bronchus in that report? "Yes" or "No"?
Is there a single word about the bronchus?
A No.
Q Okay, thank you.
Now, let's go to the report of the bronchoscopy. Now, with respect to the bronchoscopy, you said the bronchoscopy was done

improperly; is that right?
A No.
Q You said that it came to a place and then didn't go any time further; is that right? They should have made a right turn or something like that?
A What I said was --
Q Did you say something like that?
A No.
THE COURT: No. I stopped all of that. Let's go on.
Q Okay, so in any event, the report of the bronchoscopy which is, it is not communicating with any bronchus -- I'm sorry, in the report of the pathologist, forgive me. I meant pathologist.
The report of the pathologist is, "It is not communicating with any bronchus and shows

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focal area of necrosis and hemorrhage".
Do your recall that you read that? It was on the screen before.
A Yes.
Q And you said you disagreed with that; correct?
A No, I didn't say I disagreed with that.

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Q I thought you said you disagreed with that.
A If you'll let me finish.
Q Did you disagree?
A What they said --
Q Doctor, first can I can get an answer to my question?
MR. GORDON: Judge, he's trying to answer the question.
Q Did you disagree with that statement?
THE COURT: It's not a disagreement is the answer.
A It's not a disagreement.
Q So you agree with that.
A No, I didn't say that. I didn't disagree.
What I said was -- before -- that when the pathologist looks at something, a gross inspection, he inspects it. He has the mass in his hand the surgeon gave him, but in order to see communication, remember, we look at the film. There is a small communication. You would have to slice it up.
Q I thought you said you disagreed with

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that, but maybe I was wrong.
MR. KACZINSKI: Move to strike.
Q I'm looking further and it says here:
"The tumor measures 5.5 centimeters in the greatest dimension, and it is consistent with primary at this site".
Is that correct?
A Yes.
Q That means that the primary site of this tumor was in the lung; isn't that correct?
A It wasn't metastatic; right.
Q It says -- plural -- "Bronchial and vascular resection margin are free of tumor".
Did I read that correctly?
A Right.
Q Now, sir. I want you to assume that Dr. Eugene Mark who is a board certified pathologist of Harvard and also an editor, an associate editor of The New England Journal of Medicine doing case studies in pathology -- assume that he has stated that what Clyde Anderson has is lung cancer.
Will you assume that?
A Okay, I'll assume that's what he said.

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Q Will you assume further that this same Dr. Eugene Mark after viewing all of the slides

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and looking at all of the cells concluded that the cancer that he has is adenosquamous carcinoma.

Assume that. Will you, sir?

A Okay.

Q Would you now tell us please, do you, not a pathologist, disagree with Dr. Mark?

"Yes" or "No"?

A It's not a "Yes" or "No" answer.

MR. FINZ: I have nothing further.

Thank you, doctor.

REDIRECT EXAMINATION

BY MR. GORDON:

Q Dr. Fishman, Mr. Finz asked you about whether you've written on what he'd call mucoepidermoid tumors defined as MET, and I believe you said as I recall it that you hadn't written on MET. Can you tell us, is there a reason why none of your articles --

MR. FINZ: I'm going to object to that, Judge, as to why.

THE COURT: Overruled.

Q -- were on the subject of MET or

mucoepidermoid tumor?

A I may go back tomorrow and write one, but the reason you write an article is because you have some new information to share with everybody. You don't write an article just to write an article. So when I write an article, I've made a new finding, a new observation, and there is nothing new that I have discovered or can add to the literature. We don't just don't write things to write things. I write it when I discover information that I can share with other doctors, radiologists.

Q Mr. Finz also asked you the same question with regard to textbook or textbook chapters.

Do you recall that?

A Yes.

Q Would your answer be the same with regard to textbooks or textbook chapters and why you have not written on mucoepidermoid tumors?

A Right.

Q Let's talk a minute about the frequency of occurrence of mucoepidermoid. Does the fact that a type of lung tumor might be rare have any

impact on the ability to diagnose that tumor?

A No. I think it's important to understand that as a radiologist, obviously like all physicians, common things you see more often, and less common things you see less often, but that doesn't have an impact on what I do.

Just for example, last week a patient came to us --

MR. FINZ: I'm going to object to that, your Honor.

THE COURT: Overruled. Go ahead.

A Last week a patient came to Hopkins with fever, and the patient had what's called hydatid

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disease. Hydatid disease, I have seen five cases in 20 years. I know what it looks like. It's --
MR. FINZ: I'm going to object to this as being totally irrelevant to any issue in this case.
THE COURT: The only thing is it's in answer to his question.
A I know how certain tumors look. We don't see them that frequently. I have seen about ten or 12 cases of mucoepidermoid. In those cases, most of them, we actually suggest that that

is what it might be, because you know.
In some sense as a physician radiologist you at times learn more about rare things. In your mind you know about the rare things as much as you know about the common things. You don't see -- something being rare doesn't mean you're not going to diagnose or suggest doing things about it.
Q The fact that something might be rare, in all fairness to a patient for example doesn't mean you wouldn't include it in a differential diagnosis of types of cancer that you should consider.
THE COURT: Counsel, you're leading a little bit.
A I think for example --
THE COURT: Just --
THE WITNESS: Okay, stop. Okay.
Q Does the fact that a tumor, a type of tumor might be rare, have any affect as to whether you consider it in a differential diagnosis?
A The answer would be no, because if you open a textbook for example, it will discuss things in order of frequency. You look at a

textbook --
MR. FINZ: I'm objecting to this. It's outside the scope of this question.
THE COURT: The texts can cover the rare.
THE WITNESS: Will cover the rare and the common.
Q Can you give us some examples, doctor?
THE COURT: Come on. Let's move on. You don't need more than that.
Q We spoke about the AFIP. You're familiar with the AFIP?
A Yes, I'm familiar with that.
Q In fact, you teach there?
A Yes, I lecture there.
Q What kind of hospital is the AFIP? How big a hospital?
A The AFIP is not a hospital. The AFIP is Armed Forces In Pathology. What happens is people -- radiologists pathologists, whatever; medical doctors refer patients, refer films or slides there, and they give second opinions.
So one of the things to recognize with this article and a problem with that article which

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Dr. Fishman-Redirect-Mr. Gordon

I wanted to comment on before, you see is there are -- they get the rare cases. The case --

MR. FINZ: Judge, I'm going to object to all of that.

THE COURT: Overruled.

A The case with a pathologist you see that had 60 cases in 26 years, that's who referred to them. That's not a true sample of the population, because the easy cases to diagnose, they never saw. The typical statistics that people would see, the common cases you would see, they never see.

So every AFIP, whether it's pathology, whether it's radiology, is always totally excused because it's only what people sent them. It's not what's a typical frequency of diseases, and it's only the unusual.

THE COURT: Isn't that also true of a good teaching hospital?

THE WITNESS: You see both. For example, at Hopkins, 80 percent of all the patients we see are within ten miles of the hospital, so it's a good mix. And if you don't have an AFIP for

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example, how does the AFIP get cases of radiology residents? During the time spent with AFIP, you're required to bring three cases with you, so -- and you have to have good cases. So you bring three cases. That's the most --

THE COURT: I understand, but I thought that all good teaching hospitals get the rare and the difficult.

THE WITNESS: We do get the rare and difficult at Hopkins, the tertiary referral center, but the reality is when you look at the numbers which Hopkins has done, for example over eight percent of our patients come from ten miles, and in fact, that's forced them to remarket because the reality is you're not going to survive on the ten or 15 percent.

REDIRECT EXAMINATION

BY MR. GORDON: (Cont;d)

Q I want to ask you about a public case of AFIP for a second.

MR. GORDON: Could we put this up for the Court and counsel?

Dr. Fishman-Redirect-Mr. Gordon

Q I'm showing you a publication. This is from AFIP. "A Thesis of Tumor Pathology for Lower Respiratory Tract".

A Is this not the same one?

Q A different article. Have you heard of this publication, doctor?

A What's that?

Q Have you heard of this publication?

A Yes. They have a number of them in that

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series.
Q And would you consider that an authoritative publication?
A Sure.
Q I want to ask you about one passage here.
MR. GORDON: Judge, can we put this up for the jury?
MR. FINZ: Judge, there is some writing there.
MR. GORDON: We'll redact that.
(E. Spielman relieved D. Dorsey and recorded the balance of the day's proceedings.)
* * *

Fishman - Redirect - Mr. Gordon

MR. GORDON: We're waiting for him to bring it up. We're obviously having some technical problems.

Q Doctor, I want to read you a sentence here that carries over to the next page. It's the last sentence on this page and then it carries over.

The neoplasms range from several millimeters to six centimeters in diameter. Low grade tumors are almost always confined to the airway, but high grade tumors frequently extend into the surrounding lung.

I should point out that that appears in a section entitled "mucoepidermoid carcinoma of the bronchus."

My question to you is: Is that description of high grade mucoepidermoid consistent with what you told the jury with what this tumor, Mr. Anderson's tumor, appeared to be doing on the CT scan?

A Yes.

Q By the way, when Mr. Finz was asking you about the frequency with which you have seen mucoepidermoid during your career in Johns Hopkins, I seem to have recalled you

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threw out a 300 thousand students?

A That's how many I examined in total of all kinds of patients I've seen.

Q Did that number reflect just the number of patients with lung cancer?

A No, it didn't.

Q How much less than three hundred would be the number if we focused on those with lung cancer?

A I think we said this morning I've probably seen about 10,000 something, along that range, of lung cancer.

Q You were asked by Mr. Finz about the Heitmiller article. Do you recall that?

A Yes. I recall that.

MR. GORDON: Mr. Finz or Mr. London, do you have that article handy?

(Handing to Mr. Gordon.)

MR. GORDON: Thank you.

Mr. Finz, let's put this up first.

Q This is the Heitmiller article, correct, Doctor?

A Correct.

Q I believe you told us you know Richard Heitmiller?

A He's the head of thoracic surgery in Johns Hopkins.

Q You were not familiar with Dr. Eugene Mark?

A No.

THE COURT: It's usually a rule you know

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people of your only specialty and of your own

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hospital.

THE WITNESS: Absolutely.

Q I would like you to read one passage of your article that Mr. Finz did not bring to your attention. That's on page 397.

Let's see if we can bring it up a little better. "Smoking is not a major risk factor."

Do you see that statement?

A Yes.

Q Is that consistent with the medical literature on mucoepidermoid that you have seen?

A Yes, it is.

Q Mr. Finz also asked you about the A F I P article that I believe one of the authors was Yousem?

A Yes.

Q This is the Heitmiller article again. I wanted to ask you about one of the footnotes. You see footnote number 17?

A Yes.

Q Is that the Yousem article that Mr. Finz asked you about?

A Yes.

Q It stated "1987"?

A Right.

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Q Can you tell us again what the date of this article was?

A 1989.

Q Now, when I asked you about smoking and mucoepidermoid this morning, I believe you told us about a textbook; is that right?

A Right. I was reading some textbooks on the chest.

Q Is that the textbook, Doctor?

A Right. Let me see the bottom. I think it's by Theresa McCloud who is the Professor at Massachusetts General Hospital.

Q And do you know what the date of this textbook is?

A It's 1998 or 1999.

Q And the Heitmiller article was about ten years earlier?

A Ten years previous.

Q One of the chapters, I think, it's Chapter 13 is entitled "the bronchi." Do you see that?

A Yes.

Q Let me see if I can bring up the author a little better. And the author appears to be Joanne Shepard.

A Right.

Q Was it Dr. Shepard?

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A Also at Massachusetts General.

Q Doctor*** fingers reminded us that's where that Dr. Mark worked, Massachusetts General?

A Right.

Q Let me direct your attention to one passage in that chapter.

By the way, I believe you told us earlier you would consider this an authoritative text that you would rely upon?

A Right.

Q Read along with me if you will, Doctor.

"Mucoepidermoid tumors are uncommon representing .2 of all lung tumors and one to five percent of bronchial tumors. The mean patient age at presentation is 36 years. There is no sex predilection and smoking is not a major risk factor."

Did I read it correctly?

MR. FINZ: You said "major." There is no major.

Q "Is not a risk factor"?

A It's even actually better. It's more distinct. It's not a risk factor.

Q It's the word "major" which appeared in the

Heitmiller article, but did not appear in this textbook; is that right?

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A Right.

Q Now, Mr. Finz also talked about the median age. I think it was in connection with the Yousem article of patients in that study that had contracted or been diagnosed with mucoepidermoid tumors; do you recall that?

A Yes.

Q And I think you told us the median age was about 29?

A The median age was 29.

Q Does that mean that there can't be patients outside that median age either younger or older who can't be diagnosed with the same tumor?

A As it says in the article, the ages range from 29 to 78 in the Yousem article. So it's a wide range. Average or median is to give you a field relative to where most of the patients kind of lie.

But in these cases, like in the textbook you just read or in Heitmiller's article, the average range was 38 years. So it depends on your article. Typically, it's the 30s or 40s is the most typical age. But it's a wide range of when it occurs.

Q So there can be patients outside that bell curve,

if you will, that median age, which can come down with that same type of lung tumor?

A Yes.

Q I'm not sure you're allowed to explain during the

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cross exam whether or not you could differentiate from a radiological standpoint on the CT scan high grade mucoepidermoid from low grade mucoepidermoid?

A What I think you could do is be more suggestive. For example, if you had adenopathy or spread tumor from the high grade, you could see from the article recited before that things spread out in the parenchyma, it could be more suggestive.

But the thing is that pathologists would make the final diagnosis as to high or low grade.

Q Let's talk for a moment about the surgical pathology report that Mr. Finz asked you about that and I also asked you about that.

And the statement that we asked you about was one that read that the tumor did not appear to be communicated with the bronchus; do you recall that?

A Right.

Q Now, how do you correlate that statement with what you've told us about what the tumor appears to be doing on the CT scan which is encasing or surrounding the bronchus?

A Right. It's very simple because it really relates to how the pathologist looks at something grossly. It's given to someone by the surgeon who holds it in his or her hand and looks at it and says I don't see any communication.

But to see communication particularly when it's smaller branches, you need to cut the section up.

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He's looking at the big specimen given by the surgeon.

That's why there is no disagreement between the pathologist and myself. He's not looking at the detail we're looking at it. He was looking at it grossly.

Very similarly, you look at the surgical report and you look at what the surgeon says.

The surgeon is simply describing what he did. He went in. He felt a mass, took it out. The surgeon was not -- does not make a pathological diagnosis, nor does he try to.

His job was to go in, get that tumor out, made sure it left no disease behind. That's all the report reflects. Nothing more; nothing less.

Q Are you saying then that there are things that can be seen upon a gross examination?

MR. FINZ: Objection to the form of the question.

THE COURT: Sustained.

Q Are there features of a tumor that one can see on a CT scan that a surgeon or a pathologist may not be able to determine by looking at a gross examination?

MR. FINZ: Objection.

THE COURT: Well -- or has no interesting in making a determination?

THE WITNESS: Right.

The fact is that it's not uncommon for a

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pathologist who has a specimen to come see me and ask me what I think the case was likely.

And you would say, gee, why would that be? Why would a pathologist who has the tissue come to a radiologist? Because a lot of the findings that are important in making a diagnosis or are on that initial image before it was taken out of a patient. So that's not surprising. That happens everyday.

Q In your work at Johns Hopkins, Doctor, do you make diagnoses of cancer on the basis of a CT scan?

A Essentially, the answer is yes.

Q And do other doctors such as cardiothoracic surgeons or pulmonologists, whatever the specialty may be, rely upon your reading of the CT scan and deciding --

THE COURT: Sustained.

Q -- whether to operate?

THE COURT: Sustained.

Q All right. What, if anything, do other doctors that you consult with determine to do based on interpretations that you make on the CT scan?

THE COURT: Sustained. Sustained. You're not getting there.

Q Doctor, do you consult with other medical specialists in your specialty?

A Constantly.

Q What assistance do you provide in your practice?

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A What a good radiologist does and hopefully I do routinely is that we read the film, we come up with the findings on the film, suggest what the most likely diagnosis is, a differential diagnosis. And we'll tell the referring physician, suggest what needs to be done next.

For example, in this patient, you would have looked, you would have seen a mass, an airway. I would have suggested the patient needed bronchoscopy or biopsy.

What radiologists do, we're consultants, we help with the management and guidance of the patient. It's a very important role. That's what we try to do well.

Q And does that assistance that you've been

providing include whether in determining to help you operate or not?

A The answer is yes.

Q You were asked about lectures briefly concerning mucoepidermoid?

THE COURT: Oh, counsel. Must we?

Q Well, have you ever in the course of giving any of your lectures, have you ever discussed cases involving mucoepidermoid?

A Yes.

Q Why don't you tell us about that?

A In lectures on the chest that I give when I speak about lesions that involve the airways, I will show one or two examples of mucoepidermoid tumor as one of the causes

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and I will show some other lesions as well.

We will give some examples, show some other examples, as well, in showing some things to consider.

Q Mr. Finz asked you about the operative report, I believe it was. It was on a big poster board. And specifically, I think you were asked whether there was any statement in there about the tumor involving or communicating with the bronchus. Do you recall that?

A Yes.

Q Was there any statement, by the same token, in

that report that said the tumor was not communicating with the bronchus?

A No. It was a typical surgical report.

MR. FINZ: I will object to that and ask that be stricken.

THE COURT: Strike that "typical surgical report."

Can we move on?

MR. GORDON: Yes, sir.

Q You were asked about other medical specialties. You were asked about whether you're a pathologist. Do you recall that?

A Yes.

Q And a surgeon and one or two other medical specialties?

A Yes.

Q Do you recall during Mr. Finz's cross-examination

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you any questions about radiology or CT scans?

MR. FINZ: Excuse me, Judge. I will object.

THE COURT: Sustained.

MR. GORDON: Thank you, Dr. Fishman. I have no further questions.

THE COURT: Anything further?

MR. FINZ: Just a minute or two and I'll be

through.

RECROSS-EXAMINATION

BY MR. FINZ:

Q Dr. Fishman, if you saw something suspicious either on the CAT scan or on an x-ray, you would render a report of that suspicion to the physician who ordered the x-ray or the CAT scan; isn't that right?

A Right.

Q Would you ever suggest that it would be good medical practice to proceed to surgery without confirming disease pathologically?

A I think in situations , we do it all the time.

Q In other words, you'd see something on the CAT scan, you say okay let's go ahead and open the man's chest on the basis of a CAT scan? Is that what you're saying?

THE COURT: That wasn't the question you're asking. You asked a general question.

Would your CAT scan be normally followed by a bronchoscopy if that was an appropriate tool.

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Q Yes?
A I think in most cases of a lung mass.
Q Following the judge's question?
A Following the judge's question: If you see a lung mass before you operate, you would biopsy it.

Q And then you do the biopsy and you send it to pathology, correct?
A Correct.
Q And then a pathologist looks at it to see exactly what he's dealing with, what the diagnosis is, what kind of cell he's dealing with, correct?
A That's a typical.
MR. FINZ: Thank you.
Q Sir, have you ever made any studies with respect to mucoepidermoid tumors and smoking? Have you ever done that, sir in your entire professional career?
MR. GORDON: Objection.
THE COURT: Overruled.
A No, sir.
Q Your answer is?
A No, sir.
Q Finally, the pathologist, the one that looks into the microscope and looks into the actual cells themselves, is the one that makes the diagnosis as to whether or not the cell is cancerous or not; isn't that right?
MR. GORDON: Objection.
Mischaracterization.

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A Yes.

MR. FINZ: Thank you. I have no further

questions.

MR. GORDON: I have nothing further.

I'd like to mark into evidence the Heitmiller article.

THE COURT: For ID.

MR. GORDON: I think I established a foundation.

THE COURT: It's marked for ID. It's not going into evidence.

MR. GORDON: There were two additional sketches. I would like to mark it into evidence.

THE COURT: Will you let the doctor off the stand first?

Thank you, Doctor. Have a nice trip back.

(Witness is excused from the stand and leaves the courtroom.)

THE COURT: Now, as you say?

MR. GORDON: There were two sketches that the doctor drew this morning that we'd like to mark into evidence as the next defendant's exhibits perhaps A and B whatever the next number is. I can show you.

THE COURT: Do you have any problem with that?

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Fishman - Recross - Mr. Finz

MR. FINZ: No. I would also move that the drawing that I made, the rough drawing, also be marked, your Honor.

THE COURT: Fine. After I discharge the jury. We're not doing anything else today, are we?

MR. FINZ: No. Not from this end.

MR. MERRITT: We have a witness.

THE COURT: Let's go.

H A R M O N M C A L L I S T E R, called as a witness on behalf of the Defendant The Council for Tobacco Research, having been first duly sworn, was examined and testified as follows:

THE CLERK: Take your hand down. Please be seated. Give your name and business address first name middle name spelling.

THE WITNESS: First name H-A-R-M-O-N. Last name M-C-A-L-L-I-S-T-E-R.

The address is 900 Third Avenue, New York, New York

DIRECT EXAMINATION

BY MR. MERRITT:

Q Good afternoon, members of the jury.

Doctor McAllister, could you repeat for the

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jury your name, please?

A Harmon McAllister.

Q Where do you reside, Doctor McAllister?

A [DELETED]

Q Where are you employed?

A At the Council for Tobacco Research.

Q Where is the offices located?

A It's in Manhattan.

Q What is your position at CTR?

A I'm vice president.

Q You understand when I say "CTR," I'm talking about Council for Tobacco Research?

THE COURT: What do you do there?

THE WITNESS: I'm vice president.

THE COURT: Okay.

THE WITNESS: Sorry, your Honor. I'll try to speak up.

Q Doctor McAllister, are you married?

A Yes.

Q What does your wife do? Does she work outside the home?

A Yes. She's a director of a preschool program.

Q Do you have any children?

A Yes. Two.

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Q Doctor McAllister, where did you grow up? Where do you come from?

A I grew up in North Carolina. And I was born in Durham. My parents moved to Chapel Hill. And I grew up in Chapel Hill.

Q Did you attend school in Chapel Hill?

A Yes.

Q Were you did you attend college?

A Chapel Hill North Carolina. University of North Carolina.

Q University of North Carolina?

A Yes. That's in Chapel Hill.

Q Why was it that you considered going to college other than Chapel Hill?

A No, I lived at home. It was a lot cheaper.

Q What year was it that you started college at University of North Carolina?

A That was in 1954.

Q What was your major? What was your course of study at college?

A I majored in chemistry.

Q And did you receive a degree then in chemistry?

A Yes. I had a Bachelor's of Science degree in Chemistry.

Q And after you graduated from college, what year was that?

A '58.

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Q 1958. After you graduated from college in 1958, did you pursue any further education?

A Yes, I went to graduate school. Actually, in the same town, Chapel Hill, University of North Carolina.

Q And what kind of a program were you in in your graduate school?

A That was -- I was a graduate program in biochemistry in the University of North Carolina Medical School.

Q Now, biochemistry, what is "biochemistry"?

A Biochemistry is basically the study of the chemical reactions that go on in the body and what controls them.

Q And why did you continue your study in biochemistry?

A Well, I was really interested in research, frankly. I had made a decision to do that rather than go to medical school. I was always attracted to medicine. A lot of my family's friends were doctors, and I respect doctors a lot, and they treat patients, of course, and they make patients well sort of on a one by one basis.

And I really thought that with my interest in research, I might be able to actually contribute to knowledge that might eventually help even more people.

Q What sort of courses did you take as a doctoral candidate or doctoral student in biochemistry?

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A My program was pretty much like biochemistry programs all over the United States. They overlap to more or less extend with the first two years of medical school.

First two years of medical school are called the preclinical years. And I took along with the medical students pharmacology, physiology, immunology, those sorts of courses.

Q Did you take any courses on experiment design, that sort of thing?

A As part of the graduate program, we had number of courses on how to set up experiments, how to design experiments, statistics for analyzing experiments.

Q Is it required of a person who is in a Ph.D. Program in biochemistry to actually do research?

A Oh, yes. Very much so.

Q Did you do research?

A Yes.

Q In what area were you doing research?

A I was working on cancer research. The model that

we were using was for a liver cancer. We were trying to determine if there were any things in the cell nucleus, any proteins in the cell nucleus that could be responsible for liver cells becoming cancerous.

Q What are proteins?

A Proteins are actually strings of amino acids. Proteins are what you get when you string amino acids together.

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The proteins are, in fact, the main control elements in the body. They become enzymes, which control chemical reactions. Protein make up structural protein which hold pieces of the cells together. That sort of thing. They're fundamentally important in the body.

Q What do proteins have to do with cancer?

A Well, the particular ones we were looking at were ones associated with the DNA of the cell. The DNA or the genes of the cells are what has to be expressed when cells divide.

When cells divide uncontrollably, that is of course what cancer is. These particular proteins we were looking at were ones that held the chromosomes kind of in check when chromosomes shouldn't be devoided.

It was logical to think that maybe the proteins were not the right kind of proteins were damaged

in some way in cancer cells and would not keep the cells from dividing.

Q When you were a student of the biochemistry Ph.D. Program, were you required to prepare a thesis relating to your thesis?

A Yes. That's the final thing you have to prepare is a dissertation. And if there are publishable results from the dissertation, obviously they get into the scientific literature.

Q Did you publish any of the results of your

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research?

A Yes, I did.

Q As a result of that work, were you familiar with the state of the sciences regarding cancer and cancer research at this period of time?

A Oh, yeah. Graduate students really have to do that. You have to be up on that. Absolutely the very latest materials as a graduate student because professors are always trying to trip you up saying did you hear about so and so doing such and such and you have to kind of like know which is the front line, the very cutting edge as a graduate student.

Q When is it you achieved your award as a Ph.D?

A Yes.

Q In biochemistry?

A Yes.

Q What year was that?

A That was 1963.

Q Now, Dr. McAllister, you're not a medical doctor; is that correct?

A No.

Q You're a Ph.D.?

A Yes.

Q Why, if you're not a medical doctor, were you taking courses at medical school?

A Well, most biochemistry departments are in medical schools, because biochemistry is considered to be one of

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the preclinical medical sciences and medical students have to take biochemistry.

And since the curriculum overlapped so much with a medical curriculum, almost always biochemistry courses are taught in medical courses.

Q Following your Ph.D. in 1963, did you study further in the area of biochemistry or biomedical research?

A Yes. I intended to go into research as a career. And to do that, you have to specialize usually more after you finish your Ph.D. degree by going into laboratories with people who are working at particular

areas and hone your skill, so to speak, so you get a broader range of research experience outside what you did just for your Ph.D. degree.

Q What is that sort of an experience called?

A Well, since it comes after your doctoral degree, they call it a post-Doc.

Q Did you do a post-Doc?

A I did two post-Docs which is sort of standard for people going into research.

Q Tell us when did you do your first post-Doc?

A This was at the University of Michigan in Ann Arbor in the Department of Biochemistry in the university there.

Q What was the particular thing that you were interested in in going to the University of Michigan?

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A Since I emphasized about cancer research, I wanted to know about the mechanisms of enzymes and how enzymes operated.

Remember, I said enzymes are one of the types of proteins that operate in the body. And there was an expert in entomology and I thought it was two years well spent in increasing my knowledge on that.

Q So you spent two years on that post-Doc?

A Yes.

Q And you said there was a second post-Doc?

A Yes. The second post-Doc was at the University of Kentucky the medical school there in the Department of Cell Biology.

Q What was the purpose of going on the second post-Doc at the University of Kentucky?

A There I kind of got back into the cancer thing and my interest in proteins. This time it was to try to figure out how proteins are made.

Remember, I said they are assembled from the building blocks of amino acids. And the mechanism by which that happens was vaguely known but not clearly known.

And it was -- I mean even in normal cells, not just cancer cells. And since cancer involves sort of unbridled growth in the body, obviously unbridled growth is accompanied by lots of protein synthesis.

Since nobody knew how proteins were made at all, that's the area I went into. And the idea was if we

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could find out how proteins are made in the normal course of events in the division of cells, there might be something different in the way that cancer cells divide. In fact, we didn't make specific analysis of cancer cells in that particular study. We were doing normal cells.

Q Did you receive any financial support in order to

make it possible to do these two post-Docs?

A Yes. The Muscular Dystrophy Associations of America and the National Institute of Health supported me there.

Q By means of a fellowship or?

A Yes. That's right.

Q The National Institute of Health are what, just briefly? The jury has heard about them to some extent. But briefly, what is the NIH, I think it's called?

A Oh, yes the NIH is an umbrella organization, has lots of organizations under it like the National Heart, Lung and Blood Institute, The Institute of Aging Child Development.

Those are all institutes that have to do with health in the National Institute of Health umbrella. And National Institute of Health does have a large fellowship program. And that's one of the ones I had.

Q What did you do after you finished your second postop.

A I continued my research that I had done in that

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second post-Doc as a faculty member in Detroit. I was in the biochemistry division of the chemistry department there, and that's where I set up my research laboratory.

Q You were a faculty member or professor

or assistant professor there?

A Yes. That's right.

Q What type of courses did you teach?

A Well, biochemistry mostly. I taught biochemistry to nursing students, undergraduate nurses. I taught it to graduate students. And also some advanced undergraduate students.

My largest student teaching job was in the graduate area. I also taught some of the biochemistry in the medical school and of course advanced topics of research inside the department in terms of biochemistry research, biochemistry --

Q Did you as while you were a member of the faculty at Wayne State University, did you do some research?

A As a matter of fact, I continued on the same research of how proteins are assembled inside the cell.

Q Where was that research performed?

A In my laboratory. I had a couple of laboratory suites that were staffed with the graduate students, support staff, and so on.

Q In order to be able to do research in a laboratory like Wayne State University, do you have to have financial support outside the university?

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A Yes. Universities are not often well off to

support large scale by a medical research. So everyone is expected to go out and get their own grants from the major funding universities like NIH.

Q Did you have that kind of -- is that your glass of water?

A I hope it's mine.

Q I hope so, too.

Did you get financial support? And if so, from whom?

A My primary support was actually from the National Science Foundation which was another federal -- federally-funded research organization.

I did get some research support from National Institute of Health. But primarily National Science Foundation. I applied there. And they did research funds.

THE COURT: Are you finished with the -- are you ready to go into the merits now?

MR. MERRITT: There are some additional stuff.

THE COURT: Why don't you do that now? We'll go into the rest in the morning.

Q Doctor McAllister, did you publish any articles as a result of your research that you conducted at Wayne State

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University?

A Yes. And also through my post-doctoral work as well, of course. But while I was there I did publish.

Q Were those published in scientific journals?

A Yes. Usually peer-reviewed scientific journals.

Q What is a peer-reviewed journal? How does one get an article published in a peer-reviewed journal?

A Once you do the research, you write it up as a manuscript and send it to the journal editor, editor that you want it published obviously whose name is as high as possible.

The manuscript is then judged at the editorial level by people who are experts in your field. And when they judge that it's of adequate quality and in advance of science to have it published, they recommend to the editor that it be published and that it's published in the literature.

That's the basis of the peer review meaning that you send a manuscript. Other scientists look at it who are knowledgeable in the area and can criticize it and give a thumbs up or thumbs down.

Q Have you yourself ever served as a peer reviewer for journals in the biomedical area?

A Yes.

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Q How does one become a peer reviewer?

A I think it's kind of word of mouth. You get a reputation in a certain area. Editors know that you have published in good journals in a particular area, so they send you manuscripts to comment on. And you read it, you comment, you point out criticisms or words where constructively it might be improved and send it back to the editor. But it's his job to make that judgment.

Q Did you at some point while you were at Wayne State University become involved in the academic administration of the university?

A While I was at Wayne State, I joined the office of the provost which is the chief academic office of the university. It's sort of like the head of the faculty. I was the director of the office for institutional research.

Q And when was that? What year was that?

A Early 70s, mid70s.

Q While you were at Wayne State, did you do any consulting work in the area of cancer research?

A I did. Not far from my laboratories at Wayne State was the institution called the Michigan Cancer Foundation.

The Michigan Cancer Foundation did have a program of basic research although it had a very large

program of cancer therapy and cancer diagnosis. But they

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had a core of scientists who were working on problems similar to me.

The Michigan Cancer Foundation people were also interested in how proteins were assembled because of the general interest in the cancer area. And we collaborated on a number of projects.

Q How long, all told, did you stay at Wayne University?

A I think 16 years.

MR. MERRITT: This would be a good time.

THE COURT: I think this would be a good time.

Have a nice evening, folks.

(Jury leaves the courtroom.)

THE COURT: Go ahead.

MR. LONDON: Thank you, your Honor.

THE COURT: Go ahead, Counsel. Yes?

MR. LONDON: Your Honor, we're now in our sixth week of trial. Okay?

THE COURT: Go ahead, Counsel.

MR. LONDON: Your Honor, we're in our sixth week of trial now.

Defendant's psychiatrist, Dr. Philips,

examined the plaintiff over six weeks ago.

THE COURT: What are you precluding?

MR. LONDON: Dr. Philips is a psychiatrist in that he's supposed to testify. Defendant is

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supposed to be resting next week. We are yet to get a report.

MR. KACZYNSKI: And as you recall, the designated Dr. Silverman who has done an IME.

MR. FINZ: Dr. Glassman did not testify in the case in chief. We're afraid that Dr. Philips is going to come in and we'll serve a report.

THE COURT: You'll get a report.

MR. GORDON: Absolutely. I have told you that we have put the flame under this process. There should be a report done by the end of the week. It takes a little time to put together a report from the doctor.

MR. LONDON: Your Honor, I'm cognizant of the fact that you're, I guess, happy that we're resting and the case will be over next week.

But we have rested today without receiving the report from their expert who is going to come in and testify.

THE COURT: Counsel, we'll get you the report

before he testifies.

MR. LONDON: And what? On the eve of?

THE COURT: Not on the eve of? I'll make sure.

MR. LONDON: What about our case?

THE COURT: What about your case?

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MR. LONDON: Dr. Glassman is not going to be precluded for coming in as a result.

THE COURT: Counsel, I didn't stop you from rebutting where appropriate.

MR. KACZYNSKI: But I don't want his rebuttal report on the eve of.

MR. LONDON: Your Honor, also interestingly we found another case of mucoepidermoid. It was a tobacco case.

THE COURT: Of course. Good night, everybody.

(Case adjourned to Tuesday, June 6, 2000 at 9:45 AM.)

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